“We Don’t Need Your Pity, We Need Our Rights:” Understanding the Experiences of Sex Workers within the HIV Continuum of Care in the United States

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Forward

This project serves as an undergraduate honors thesis within the Health and Human Biology Department at Brown University. This thesis was completed during my eighth semester at Brown University after three semesters of carrying out research as a part of my senior experience within the Health and Human Biology Department. This thesis serves as a fundamental part of my curriculum within the Health and Human Biology concentration and integrates much of what I have been studying over the course of the past four years into a single project. This thesis serves as a partial fulfillment of honors and of an independent study within the Biology department.

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This honors thesis would not have been possible without the dedication and support of many activists, advisors, and peers. The interdisciplinary nature of this project required an immense amount of time, discussion, and consideration between individuals working in many different fields, all of who made this project happen.

I first began working with Call Off Your Old Tired Ethics Rhode Island (COYOTE RI) in early 2017 putting together trainings for local service providers on best practices for working with people involved in the sex industry. During this time, COYOTE RI carried out a research project that reached over 1,500 current and former sex workers nationwide. The strong support for this project came from the deep trust sex workers nationwide have in COYOTE RI given the organization's ongoing dedication to vocally advocating for the rights of sex workers. The candor and honesty in the surveys collected reflects this trust and the urgency of the questions to many sex workers and in this project I analyze many of the surveys collected through this research project. I am incredibly grateful to COYOTE RI and COYOTE RI's executive director Bella Robinson for supporting me in becoming involved in their work, educating me on the current position of the sex workers rights movement, and allowing me to work with the anonymous surveys collected through this nationwide research project. As an undergraduate it can be difficult to establish meaningful and long-lasting relationships with community-based organizations and develop research projects in collaboration through which I can use the tools academia has provided me. I am so fortunate to have been able to work in this way with COYOTE RI and am incredibly grateful to COYOTE RI for being welcoming and supportive of this honors thesis.

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Abstract

Introduction: This study explores the experiences of sex workers within the HIV continuum of care (CoC) that is made up of HIV education, prevention, and treatment in the United States. Sex workers have long been framed as vectors of disease within the United States and this study looks to provide and understand alternative narratives of disease, disease prevention, and wellness among sex workers. This project explores the experiences of the HIV CoC specific to sex workers and situates these experiences in a historical context. This research examines how and why these experiences diverge from those of the general public and explores how the HIV CoC could be more sex worker friendly and what operating within a rights-based framework would look like for the HIV CoC. Carried out through community-based research, this project also highlights the importance of research that is developed by sex workers and informed by their understanding of the nuances of the sex industry and decades of experience in organizing to promote better conditions for sex workers. Through this human rights-based approach, this research explores how the HIV CoC can serve to alleviate or prevent discrimination faced in other sectors of a sex worker's life.

Methods: This mixed-methodology project analyzed two sections of a community-based survey collected by a sex workers rights organization [n = 711]. All participants reside in the US and are currently working in the sex industry or have worked in the sex industry in the past. Analytical tools used include qualitative, quantitative, document, and ethnographic participant analysis. Qualitative analysis through grounded theory served as the primary analytical tool. Through this method, primary research questions were developed after reading through the survey responses as to avoid assumptions or biases.

Results and Discussion: Based upon the experiences of HIV negative sex workers within the HIV CoC.

1. Divergent experiences and discrimination: Analysis found that sex workers experience preventative, screening, and educational services within the HIV CoC differently than the general public. Findings include that sex workers are hesitant to disclose their occupation (58% have never disclosed), face discrimination when their occupation is disclosed, field inappropriate questions or advances due to their work, and find assumptions about their health behaviors being made.
2. HIV as an entry point to general healthcare: Analysis also showed that HIV care services serve as the entry to more general health services for many sex workers.
3. Effective care for Sex workers**:** This research found many concrete ways HIV care could serve sex workers more effectively. Findings include: publicizing acceptance of sex workers, treating sex workers with the same respect as other patients, not making assumptions about the health risks of sex work, and sex worker-specific training. To improve the experiences of sex workers within the HIV CoC, it is critical to reconsider and avoid assumptions about the needs of sex workers and acknowledge how their work is separate from the discrimination they face outside of healthcare due to restrictive policy and widespread stigma. This study finds that alleviating social isolation is key in maintaining health. The nature of this research as a community-based project also speaks to the importance of grassroots organizing among sex workers to create support networks among a population that is often isolated socially from each other and the public.
4. Imagining Alternatives: Through looking to the sex workers rights movement in Brazil it is possible to understand how sex workers can be included in constructing an HIV CoC that is effective and just for sex workers and non-sex workers alike. Additionally, in considering alternatives to the HIV CoC in the US at this moment, it is important to consider the growing anti-trafficking movement and the increased policing of sex work through rescue organizations and legislation such as SESTA and FOSTA.

Conclusion: Sex workers have been identified as a key population in HIV/AIDS research and care but current measures do not effectively reach and care for this population. Understanding the distinctions between healthcare that treats sex workers as vectors of disease as opposed to patients whose rights should be upheld is critical in reconsidering how the HIV CoC could better care for sex workers. Changes within the structure of HIV services and the way in which providers interact with sex workers could allow sex workers to maintain HIV-negative status and improve their health more broadly. Acknowledging and working to remove stigma within HIV care could serve to provide an example of how other sectors should be framing their work that addresses sex workers; through a right-based approach in which sex workers are listened to and supported as any other population would be.

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Introduction: Human Rights within the HIV Continuum of Care and the Sex Workers Rights Movement in the United States

In the United States, moral condemnation and strict policing have long accompanied working in the sex industry.[1] The belief that sex workers are responsible for the outbreak and spread of numerous sexually transmitted infections has furthered this judgment and punishment throughout US history.[i] Within the realm of public health, the first widespread research on syphilis and gonorrhea during the Progressive Era designated sex workers as a "social evil" and dangerous vectors of disease.[2] This perception of sex workers as a primary cause of STIs does not remain intact today in the way it existed in the Progressive Era, but has influenced the development of modern healthcare practices. The emergence of HIV in the US in the 1980s brought about another wave of concern that sex workers would infect citizens across the US and HIV research in the 1980s and 1990s designated sex workers as primary vectors of transmission.[3] In the decades since, sex workers have been identified as a key

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This study uses the term "sex worker" to describe anyone working within the sex industry. This includes work that is both legal and illegal in the United States, legal work including performing in pornography, stripping, professional bondage, domination/submission, sadism/masochism (BDSM), phone sex, and camming. Services illegal in the United States include escorting (exchange of money for sex, dates, and time spent together), working in a brothel (exchange of sex for money at a consistent location, brothels are legal in parts of the state of Nevada in the United States), massage and bodyrubs that include sexual services, working as a street based worker that exchanges sexual services for money. Additionally, survival sex, or the exchange of sexual services for money or goods due to immediate, extreme need, can be considered sex work as well, though the economic constraints and pressure must be considered. The term sex worker is sometimes viewed as a synonym or euphemism for "prostitute", but "sex workers" is a more general term. Within this thesis, respondents working in different areas of the sex industry are grouped together and all referred to as sex workers unless otherwise specified.

The term "sex worker" does not carry much of the stigma that terms such as "prostitute" or "hooker" are often used with. Many respondents identify with or reclaim these terms, but this study chooses to use "sex worker" per the recommendation of sex workers rights organizations. The term "sex worker" originates in the work of activist Carol Leigh and is the term sex workers rights organizations suggest academic publications use when referring to people working in the sex industry. NSWP participation in the global response to HIV/AIDS was largely responsible for the terms 'sex worker' and 'sex work' replacing 'prostitute' and 'prostitution' throughout much of academia. This language moves global understandings of sex work toward a labor framework that provides solutions to many of the problems faced by sex workers.

population experiencing a disproportionate incidence of HIV and focused upon in HIV research and care.[4]

The relationship between sex work and HIV remains of great interest in the United States, but is often studied in isolation from other areas of the lives of sex workers. Subjects such as the pervasive stigma surrounding sex work and the criminal status of many parts of the sex industry remain less central to mainstream discussions of the sex industry than the subject of HIV among sex workers. For many decades, rights-based groups founded by and for sex workers have pushed back on this myopic view of HIV as independent from the conditions of sex workers within the US. Sex workers rights advocates view health as a right that can only be upheld along with the rights to fair labor conditions, housing, education, and freedom from violence and stigma.[5] This approach also emphasizes the importance of understanding how discrimination and violence along the lines of race, class, gender, sexuality, disability, and immigration status compound the difficulties sex workers face in maintaining their human rights. This rights-based approach situates HIV within a much broader context than public health; however, the conclusions of work focused on solely HIV and sex work are similar. Positive outcomes regarding HIV among sex workers can only be achieved through support inside and outside of healthcare.[6]

This thesis looks to understand the experiences of sex workers across the United States within the HIV continuum of care (CoC), which is the educational, preventative, and treatment programming surrounding HIV. Through a multi-methodological analysis, this research looks to explore what the experiences of sex workers within the HIV CoC are and how these experiences relate to the historical and current view of sex workers

in policy and public perception. The multi-methodological design of this study not only fills in the gaps in analysis that may appear between methods but also examines areas of disagreement or agreement between fields and what this dissonance signifies. This examination of the experiences of sex workers within the HIV continuum of care grants an understanding of how existing healthcare structures serve or fail this key population. Situating these experiences in the broader context of sex workers rights creates ways in which the HIV CoC could more effectively and compassionately care for sex workers and address discrimination faced in other areas of a sex worker's life.

Primary Areas of Research

Three primary areas of inquiry were developed for this research a priori based on a literature review and during the course of data analysis using grounded theory. Qualitative analysis using grounded theory involves reading through and beginning to code the data as a way to formulate primary areas of research.[7] In this way, the data itself guides the major questions being asked and areas of inquiry in this project in order to avoid assumptions, biases, and expected outcomes in the primary questions being investigated. The three main questions include:

1. How sex workers experience the HIV CoC in the United States.

   Why these experiences occur and the influence of: morality, Lack of training, Disclosure, Income verification, and Nature of sex work. How the narrative of *sex workers as vectors of disease* plays into treatment. Ways in which this narrative still exist and is true or untrue. How this impacts the quality of care sex workers receive. Potential positive and negative impacts and ways in which this dynamic creates a

complete or incomplete picture of patient health. Disclosure of sex workers status in clinical encounters.

2. How the HIV CoC may serve as an entry point to other areas of healthcare for US sex workers.

   Whether or not sex workers use screening/preventative STI services to enter other forms of healthcare. How this impacts primary care. What experiences are noted regarding full disclosure of sex worker status and the HIV CoC providing access to those generally without access to primary care.

3. How the HIV CoC serve sex workers better through a rights-based approach, what would this look like, and what the implications of these changes would be.

   What Sex workers want from the HIV continuum of care, on its own and as relates to other healthcare. What sex workers think sex worker friendly care looks like. How sex worker's needs are different than other groups and how these differences should be addressed. Possibility of providing HIV services within a rights-based approach. How a right-based approach is different from current the existing approach. Whether or not the conclusions are similar. How current clinical/public health work could function within a right-based framework and what forms of policy and/or public perception change would be necessary. If rights-based, whether or not the HIV continuum of care and sex worker friendly healthcare in general could serve as a site to: Remedy discrimination in other sectors OR Influence stigma in and out of medicine and serve to prevent and remedy discrimination.

This thesis looks to answer these three primary questions and also imagine what alternative the existing HIV CoC could look like. Current public health literature and

healthcare guidelines address sex workers as a patient population in need of care; however, much of the interest in sex workers is founded upon the history of moral disapproval and the idea of sex workers as vectors of disease.[8] Language in HIV research has largely shifted away from designating sex workers as vectors of disease, but this study looks to see if this notion remains in clinical encounter and HIV programming. Through hearing directly from the respondents of this survey is it possible to fully understand the realities of whether or not healthcare continues to regard sex workers as vectors of disease. This qualitative analysis also allows for the experiences of sex workers within healthcare to be understood as multi-faceted and impacted not only by stigma and policing specific to sex workers but also stigma, policing, and violence born out of racism, classism, transphobia, homophobia, ableism, and anti-immigrant sentiments.

The HIV Continuum of Care in the United States

As this project focuses on the experiences of Sex workers within the HIV CoC within the United States, it is first necessary to understand what the HIV CoC encompasses. This term refers to a loosely organized network of services and programming related to HIV rather than to a well-defined and structured system. The Center for Disease Control defines the CoC as four primary steps: diagnosis and screening, linking to care, received and retained in care, and viral suppression so that the levels of virus in the blood remained at a level that would make infecting other people unlikely.[9] Within this project and other recent publications, this continuum of care also includes preventive services for HIV negative populations. These preventative

services include education surrounding HIV, harm reduction efforts (needle exchanges, condom distribution, PrEP), and viral suppression as prevention of further infections. In this way, the HIV CoC does not impact only HIV positive populations; HIV negative populations may become very involved in the CoC through screening and preventative measures.

Research on Sex Workers and HIV

Given the far-reaching impacts of HIV and HIV prevention efforts, research on topics surrounding HIV occurs in almost every academic field and over thirty years of literature now exists on HIV. Research on HIV/AIDS does not fall within the HIV CoC but will also be discussed throughout this project because research on HIV is fundamental in developing the HIV CoC that exists today. Research also plays a critical role in shaping how different populations are perceived through the conclusions that are made about these populations and their relationship to HIV incidence and transmission. HIV research constructs the framework through which these populations are regarded and cared for in clinical encounters in addition to outside of healthcare settings. This project will examine primarily HIV research that is carried out through a public health and medical sciences framework. Research operating within a public health framework is population-based and emphasizes collective responsibility for health, health protection and disease prevention.[10] Tools used within public health are varied but may incorporate social science, biological, or clinical methodologies.

Within public health research, sex workers have been defined as a key population that experiences disproportionate rates of HIV infection. Other key

populations reported by the WHO include men who have sex with men (MSM), injection drug users (IDUs), transgender women (TW), and people in prisons and other enclosed settings.[11] Sex worker's designation as a key population allows for research on sex workers and HIV to be prioritized, and a large volume of literature on sex workers and HIV has been written in the past 20 years. From January 2000 to December 2018 along, 776,000 publications can be found on the search engine Google Scholar and 4,313 publication on PubMed that address sex workers and HIV. This research studies the incidence of HIV among sex workers, behaviors that cause HIV infection in sex workers, how sex workers spread HIV, and effectiveness of HIV interventions with sex workers.

In recent years, research on sex workers and HIV has remained a priority among HIV research. These recent publications arrive at very different conclusions than publications from twenty and thirty years ago that largely concluded that sex workers remain a threat to the general public as HIV carriers.[12] These recent publications, and reviews of these publications, find that sex workers engage in health behaviors that are largely similar and in many cases more cautious than the general public.[13] Many of these studies find that behaviors that make sex workers more susceptible to contracting or spreading HIV are often brought about by economic constraints such as being pressured into having unprotected sex for more money by clients.[14] [15] Additionally, these publications highlight that there are many structural barriers sex workers face in accessing the same quality HIV care that other populations utilize to prevent or treat HIV.[16] In addition, many of these papers find that stigma, violence, and legal persecution of sex workers contribute to poor HIV outcomes among sex workers and

that in order to improve HIV outcomes, other fundamental rights of sex workers must be upheld.[17][18][19][20] In this way, current public health literature arrives at a similar conclusion to much of the work being carried out in the realm of the sex workers rights movements: that in order for HIV incidence to decrease among sex workers, their rights in all areas of life must be upheld.

Key Populations and PEPFAR's Anti-Prostitution Pledge

This study follows the more than thirty years of publications referenced above that examine the relationship between sex workers and HIV/AIDS.[21] Throughout this complex history, the way in which sex workers have been defined and regarded within the field of public health has remained dynamic. Prior to the emergence of HIV, biomedical publications were largely concerned with sex workers in relation to sexually transmitted infections such as syphilis and gonorrhea and regarded sex workers as vectors of disease.[22] While described as a "vector for transmission" in earlier HIV publications, sex workers are now defined as a key population within the field of HIV. The designation of key population means that the group experiences a disproportionate incidence of HIV.[23] Many recent studies have supported this designation, with sex workers being shown to experience a rate of HIV infection 15 times that of the general US population: 12% HIV infection among sex workers as opposed to 0.7 – 0.9% among the general population.[24] As a key population, additional support is given to programming and research focusing on sex workers by federal governments and international organizations such as the UN and the WHO.[25] Despite the intention of caring for sex workers as a key population, two key events from the past 20 years

suggest that current HIV interventions are working through a framework that is not effective in caring for the health of sex workers and continues to view sex workers as dangerous vectors of disease instead of a population worthy of care and inclusion in HIV efforts.

The US President's Emergency Plan for AIDS Relief (PEPFAR) was signed into law 2003 to provide financial support for HIV/AIDS programs across the globe, with a focus on Africa.[26] PEPFAR allocated funding for HIV education, prevention, and treatment programs, and in order to receive PEPFAR funding, low and middle-income nations had to agree to a series of conditions. One of these conditions is an anti-prostitution pledge (APP) that requires nations receiving PEPFAR funding to pledge to instate and adhere to laws criminalizing sex work.[27] The PEPFAR guidelines explain that the program is "opposed to prostitution and sex trafficking because of the psychological and physical risks they pose for women, men and children."[28] Supporters of this pledge declared that criminalizing sex work was critical to "solving" the HIV/AIDS crisis, under the belief that sex work is exploitative and sex workers harbor and spread the virus.[29]

Since the creation of PEPFAR, a UN report on discussing sex work and HIV has been published. HIV and the Law: Risks, Rights and Health concludes that decriminalizing sex work worldwide would improve health outcomes across the board and calls for sex work to be decriminalized.[30] PEPFAR policies have been brought to court, and in June 2011 a US appeals court ruled that the pledge violated the US Constitution. As a result, the government cannot enforce the pledge against US-based members of InterAction and Global Health Council.[31] However, the APP remains in

place for organizations outside the US, and the few US organizations not protected by the lawsuit.[32] Pushing the criminalization of sex work via this pledge cuts sex workers off from critical HIV care and other supports systems in their lives. Healthcare providers, researchers, and activists worldwide criticized this policy for endangering sex workers worldwide.[33] This policy also imposes the US belief of sex work as morally reprehensible and criminal in regions where it was not previously regarded as such.[34] Many nations such as Cambodia and Bangladesh tightened anti-prostitution laws in response to this relief plan in order to maintain funding for HIV services that previously supported sex workers.[35] Other nations, such as Brazil, refused the $40 million of funding in protest of the anti-prostitution pledge.[36] Brazilian authorities declared that this requirement undermines the country's efforts to fight HIV/AIDS, which have traditionally included policies written based upon the recommendations sex workers. In this way, the PEPFAR program was made aware that the contributions of sex workers have been critical in developing comprehensive HIV programming in Brazil, and that explicitly opposing prostitution would not only make the lives of sex workers more difficult but would also alienate a key ally in developing HIV care. This message was clear and public but did not result in any changes to the policy, and the PEPFAR conditions include the anti-prostitution pledge to this day.

Exclusion from the 19th International AIDS Conference and The Sex Workers Freedom Festival

Nine years after PEPFAR was put into place, another key event in the relationship between the field of HIV in the US and sex workers rights took place. In

2012, the 19th International AIDS Conference was held in Washington, D.C. to celebrate the Obama administration's repeal of the travel ban on HIV positive individuals.[37] This revised policy allowed HIV positive individuals to enter the country for the first time in 22 years. However, the travel ban on sex workers and injection drug users entering the United States remained, and no open sex workers were able to enter the country to attend the conference. Hundreds of sex workers had planned on attending and presenting at the conference, as they had contributed to efforts worldwide to address HIV.[38] In reaction to the travel ban and continued alienation of sex workers within HIV programming through US policy, the Sex Workers Freedom Festival was organized in Kolkata, India. A gathering of over 550 representatives from sex workers rights organizations from 41 countries, this festival coincided exactly with the 19th International AIDS Conference (working with the 9.5 hour time difference). Attendees of the Sex Workers Freedom Festival presented their findings and workshopped with sex workers carrying out similar work in other environments.[39] By the end of the festival the attendees had outlined a statement in which they demanded seven freedoms for Sex workers.[40] The seven freedoms for sex workers included:[41]

1. Freedom of movement and to migrate.
2. Freedom to access quality health services.
3. Freedom to work and choose occupation.
4. Freedom to associate and unionize.
5. Freedom to be protected by the law.
6. Freedom from abuse and violence.
7. Freedom from stigma and discrimination.

These freedoms align with many of the conclusions reached at the International AIDS Conference in the United States: in order for the HIV crisis to be solved, human rights in other areas of life must be upheld.[42] Even in the presence of similar findings, and ultimately the same desire for individuals and communities to live healthy lives, a disconnect remains between the HIV field in the US and sex workers, as shown by these two events and others. This study looks to understand the realities of navigating the HIV CoC as a sex worker in the United States and how these realities came to be. Through exploring how and why the HIV CoC in the United States cares for sex workers in the way that is does, it is possible to imagine how the HIV CoC could more effectively and compassionately treat sex workers. Examining the work and demands of sex workers rights movement can provide additional insight into how HIV among sex workers can be more justly addressed.

The Sex Workers Rights Movement and Community-based Research

As mentioned earlier in this introduction, the sex workers rights movement supports a human rights-based approach to addressing the health and wellness of sex workers. Sex workers worldwide spearheaded this movement through organizing around issues most pressing to them and advocating for their human rights to be upheld. Meetings among international sex workers organizations, such as a pre-conference meeting before the 2014 AIDS Conference in Melbourne, Australia allow sex workers' voices to be heard globally. At this event, organizations from over thirty countries put together a series of consensus statements that emphasized that sex

workers as rights-bearers and deserve to be treated as such [Full Consensus Statements can be found in Appendix 3].[43][44][45][46][47]

Global Network of Sex Work Projects (NSWP)

The grassroots organizing that preceded this conference created international organizations, primarily the Global Network of Sex Work Projects (NSWP), a membership organization that was founded in 1990 following the 2nd International Conference for NGOs working on AIDS in Paris.[48] NSWP "has influenced policy and built leadership among sex workers and facilitated the development of regional and national networks of sex workers and sex work projects. NSWP questions the stigma of sex work and advocated for the greater recognition of sex workers as rights bearers, with the capacity to make a difference."[49] NSWP releases statements from the perspective of sex workers and is made of up many smaller, separate groups worldwide.

These groups exist use many different strategies to influence public perception of sex workers, policy regarding sex work, and organize sex workers to support each other in the absence of societal support. Durbar Mahila Samanwaya Committee (DMSC), a sex workers rights group based in Kolkata, India, has founded a bank for sex workers and a school for the children of sex workers.[50] In the United States, an application created by SWOP Behind Bars called Heaux serves as a virtual blacklist for sex workers to report violent clients so that other sex workers can avoid them and remain safe without involving the police and putting themselves in danger of arrest. A Zimbabwe based group, Pow Wow, hosts Income Supplementation Days in which activities are organized for sex workers to make additional money to give them more

freedom and flexibility in the their work in the sex industry.[51] In this way, the grassroots efforts mentioned along with many others provide supports in many areas to fight against the dangerous impacts of social isolation.

Intersectionality and the Sex Workers Rights Movement

Within the sex workers rights movement, the use of the theory of intersectionality allows for a more complete understanding of the stigma and violence that characterize the realities of sex workers. Legal scholar Kimberly Crenshaw's application of intersectional theory discusses how hegemonies of race and womanhood are not discreet but rather mutually reinforcing.[52] Crenshaw uses intersectionality to conceptualize how multiple systems of oppression, specifically racism and classism, exist in combination in the experiences of black women and writes:[53]

> Consider an analogy to traffic in an intersection, coming and going in all four directions. Discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happens in an intersection, it can be caused by cars traveling from any number of directions and, sometimes, from all of them. Similarly, if a Black woman is harmed because she is in an intersection, her injury could result from sex discrimination or race discrimination. . . . But it is not always easy to reconstruct an accident: Sometimes the skid marks and the injuries simply indicate that they occurred simultaneously, frustrating efforts to determine which driver caused the harm.

Sex workers often hold identities that lie within multiple systems of oppression acting in combination to compound their struggles within healthcare and other areas of life.[54] In

this way, understanding one form of oppression, such as the stigma and policing of people working in the sex industry, is only possible through understanding both other existing systems of oppression and the interactions between these systems of oppression. The experiences reported in this study can only be fully understood through also taking into account: racism, homophobia, transphobia, racialized misogyny, ableism, xenophobia, and classism under capitalism. These systems privilege some and brutalize others and oppression in one area [class, race, gender non-conformity] may lead to difficulties gaining employment outside of the sex industry or additional struggle within the industry. Learning from and working to support other rights-based movements fighting stigma and violence is integral to the work of sex workers rights organizations worldwide. A statement issues by SWOP Behind Bars for International Day to End Violence Against Sex Workers states:

> The majority of violence against sex workers is not just violence against sex workers—it's also violence against trans women, against women of color, against drug users, against immigrants. We cannot end the marginalization and victimization of all sex workers without also fighting transphobia, racism, stigma and criminalization of drug use, and xenophobia.

The sex workers rights movement's use of intersectionality to conceptualize their work allows for programs and advocacy that encompasses the range of all sex workers lives. Sex workers rights organizations globally work in solidarity with other rights-based movements and understanding the intersection of different systems of oppression is a foundational aspect of the sex workers rights movement in the US.

The Sex Workers Rights Movement in the United States

In the United States, there are a number of key players in the sex workers rights movement. Margo St. James formalized what became the modern sex workers rights movement in the United States in the 1970s.[55] St. James founded Call Off Your Old Tired Ethics (COYOTE) in 1973, the first US-based organization founded with the mission of decriminalizing sex work and improving living and working conditions for sex workers. The data set used in this thesis was collected by Call Off Your Old Tired Ethics Rhode Island, the Rhode Island Chapter of COYOTE. Rhode Island is notable in that indoor prostitution was legal from 1980 – 2009, in large part due to the efforts of Margo St. James and COYOTE in the 1970s. In 2009, the original ruling was overturned, indoor prostitution became illegal again, and COYOTE RI was founded in reaction to this policy change that put many sex workers in danger.[56] Contributions to this movement have come from many other communities and since the foundation of COYOTE in the 1970s, additional organizations have been founded such as the Sex workers Outreach Project (SWOP), the Prostitution Policy Watch, and the Desiree Alliance.

These organizations and collectives call for the human, labor, and civil rights of sex workers to be upheld globally. Sex workers rights organizations work through harm reduction programs, direct services, political advocacy and health services for sex workers. The primary goals of the sex workers rights movements include allowing sex workers to work, choose occupation, associate, and unionize. The goals of the movements also include improving access quality health services, protecting sex workers under the law, and upholding the right of sex workers to exist with freedom from

abuse, violence, stigma, and discrimination. This movement emphasizes the importance of fighting against stigma and various forms of violence, such as interpersonal and state violence, as foundational for all of these goals to be met.

Community Based Research in the Sex Workers Rights Movements

Sex workers rights organizations have been conducting community-based research for decades. Sex workers and their allies carry out this research to answer key questions about how to uphold the rights of sex workers. NSWP publishes a yearly peer-reviewed journal, "Research for Sex Work," that compiles and publishes "community-led research and lived experiences, and reports on sex work within a rights-based framework."[57] Through their lived experiences, individual sex workers and sex workers rights organizations conducting research are able to understand the nuances of the sex industry. Through pre-established networks and trust, community-based research is able to access information that non-sex worker public health researchers are often unable to access. Most importantly, community-based research works with the communities the research is being conducted in to ensure that the research can be used in the best interested of sex workers themselves. Grassroots organizations comprised of sex workers are dedicated to addressing violence and discrimination sex workers face and the research produced is directly reflective of this position.

Decriminalization, Legalization, and Partial Legalization of Sex Work

In the United States, the sex workers rights movement calls for decriminalization, not legalization, of sex work. Decriminalization is the removal of laws against all forms of sex work. By contrast, the term legalization refers to a system of governmental

regulation of sex workers in which sex workers are licensed and required to work in specific ways. This is currently the practice in Nevada, the only state in the United States where brothels are legal. Although legalization can also imply a decriminalized, the reality is that in most 'legalized' systems the police control prostitution with criminal codes [58]. Lawmakers and activists in the United States have also proposed the Nordic Model, in which sex workers can work legally but buying sex is criminalized. The sex workers rights movement does not support the Nordic Model for it leaves sex workers without a jobs, furthers stigma against sex workers, and still increases policing and surveillance of sex workers.[59]

Sex Trafficking and the Sex Workers Rights Movement

In the past decade, concerns surrounding sex trafficking within the United States have grown immensely and many new laws surrounding sex trafficking have been put in place on local, state, and federal levels.[60] The sex workers rights movement: [61]

> Vehemently oppose(s) all forms of human trafficking and child prostitution. The victims of these crimes deserve our compassion and support; those who exploit others in such a manner deserve severe punishment.

However, the sex workers rights movement also calls for consensual adult sex work to be recognized as separate from sex trafficking. Trafficking involves force, fraud, or coercion and many people work in the sex industry by choice.[62] The sex workers rights movement acknowledges that this distinction is not always clear-cut, for example the example of individuals working within the sex industry and that want to exit but are unable to because they cannot support themselves financially otherwise. The sex workers rights movement supports the agency of people working in the sex industry;

they should be safe and free to work within the industry but also safe and able to work outside the industry without discrimination if they choose to exit.

Motivations for this Study

One of the major goals of COYOTE RI's research is to understand the realities of the US sex industry in the face of the increasingly visible sex-trafficking narrative. The data set collected by COYOTE RI and analyzed in this thesis looks to explore the experiences of people in the US within the sex industry and anti-trafficking programs and provide a more complete view of the US sex industry than has been previously available. This thesis considers the sex trafficking narrative and how it interacts with a biomedical framing of sex work. Since the emergence of HIV, sex workers have frequently entered mainstream discourse through discussions surrounding HIV infection and HIV transmission. If sex workers are often only talked about in terms of HIV, what does that mean for sex workers? How is the HIV care sex workers receive impacted and how might their health become isolated from other areas of their lives? Do rights remain part of this CoC? These questions serve as a jumping off point for this project and foundation for the primary research questions listed earlier that were further developed during analysis.

The interdisciplinary nature of this study allows sexual health to be framed as an area of sex workers' lives and the study of sex workers' lives that is not exceptional but rather one facet of the complex lives of people working in the sex industry. This study examines the history of HIV care for sex workers and the sex workers rights movement while being grounded in the field of public health. Public health is one of many

disciplines through which sex work can be understood. Solutions within one particular field may come from other disciplines through introducing outside conclusions and methodologies or making apparent incongruences in how sex workers are regarded Similar to the COYOTE RI research, this thesis operates on the belief that sex work is not inherently exploitative, but rather a form of labor. This research explores many of the dangers that accompany sex work in the US but looks to separate the sex work itself from the stigma, discrimination, isolation, and violence that accompany working in the sex industry. This study acknowledges that sex workers face stigma, both structural and interpersonal, in many areas of their lives and there is a large existing body of literature that examines the nature of this stigma.[63] However, stigma is an existing stereotype and prejudice, making it more difficult to measure than discrimination, the behavior that results from this negative stereotype. This study measures discrimination that sex workers face within the HIV CoC and discussing what discrimination indicates about underlying stigma.

The survey developed by COYOTE RI is based on a prior study conducted in Rhode Island in 2015 and survey conducted by another sex workers rights activist, Tara Burns, in Anchorage, Alaska in 2016.[64] This 145 question survey was conducted nationwide and touches on all areas of life including family, labor, experiences with criminal justice systems, education, housing, health, and HIV care. The survey sample analyzed in this study included a total of 711 respondents from across the United States, of whom 82.8% were cisgender women, 94% were US citizens, and 51% had graduated from or attended some college [see Appendix 2 for complete demographics].

This project analyzes two sections of the COYOTE RI survey, the demographic section and the health section.

This study uses interdisciplinary methodologies to examine the experiences of sex workers within the HIV CoC and considers the rights of sex workers in exploring their interactions with the HIV CoC. Key to this research is the definition of a rights-based approach as a conceptual framework that is based on international human rights standards and operationally directed to promoting and protecting human rights [Abbreviated United Nations Declaration of Human Rights available in Appendix 4]. This thesis examines how interventions within the HIV CoC are or are not rights-based and what it would mean to make a shift to a rights-based approach. The methods section of this thesis can be found in Appendix 1 and expands upon how qualitative, quantitative, document, and ethnographic participant analysis are used in analyzing the surveys collected by COYOTE RI. Chapter 1 of this thesis explores the experiences of sex workers within the HIV CoC in the United States and how these experiences diverge from those of the general public. Chapter 2 details how the HIV CoC functions as an entry point to other forms for healthcare for sex workers and Chapter 3 explores the recommendations of sex workers regarding the HIV CoC. Chapter 4 looks to imagine alternatives to the current state of HIV care for sex workers through examining the work of sex workers outside of the United States and expanding on the position of sex workers within the United States outside of healthcare. This thesis presents these four main areas as separate chapters and each chapter includes both the results gathered during analysis and a discussion of these results, situating the data in a historical and

social context. Through these four main areas this thesis looks to better understand the relationship between the HIV CoC, sex workers, and human rights.

Chapter 1: Understanding How Sex Workers Experience the HIV Continuum of Care

The results of qualitative and quantitative analysis indicate that sex workers experience the HIV continuum of care in the United States differently than people that have never worked in the sex industry. This research looks to situate the experiences described by respondents in a historical context in order to understand why these experiences happen and how existing HIV structures and perception of sex workers came to be.

Sex Workers and Moral Prophylaxis during the Progressive Era

The United States has a long history of regarding sex work as an immoral activity that leads to sickness not only for the sex worker, but also for society as a whole.[65] During the Progressive Era, the period in the United States between 1898 and 1917, many developments took place in the field of public health amid broader social, political, and industrial change. Following the Spanish-American War the US emerged as a great power and vast changes occurred in communications, transportation, immigration, migration, gender roles, family structure, class structure, work patterns, business methods, education, intellectual life, religion, the professions, technology, science, and medicine.[66] The scope and feel of people's lives and relationships rapidly transformed and in many ways the events of era set the agenda for the rest of the 20th century.

Public health practices became more institutionalized during this era and in 1905 The American Society of Sanitary and Moral Prophylaxis was founded to promote sex education and study the “sanitary, moral, and administrative” ways in which prostitution could be eliminated.” [67] This organization looked to eliminate syphilis and gonorrhea and was based on the notion that venereal disease is retribution for sexual immorality

and that social evils must be removed in order for “the race” to flourish.[68] “The race” refers to the white middle and upper class and the efforts of the social hygiene movement of the Progressive Era was founded upon protecting “the race.” The social hygiene movement focused on abolishing vice industries, such as prostitution, gambling, and alcohol, throughout the country. Prior to 1915, prostitution was illegal only in streets and tenements in cities such as NYC, and there were many loopholes that allowed women to practice prostitution even in these locations.[69] However in 1914, NYC legislature passed the Herrick Injunction and Abatement Law removing legal loopholes and making prostitution illegal in all parts of the city.[70] Many brothels closed in the following years, police involvement in prostitution steeply decreased, and newly enacted laws were strictly enforced.[71]

Medical and moral framings continued to exist in conjunction; the prostitute remained stuck in the paradigm of being viewed as both the helpless victim in need of saving and the sexually deviant locus of disease. Laws constructed during the Progressive Era had an immediate impact on the practice of prostitution, and laws created during this era, such as the Mann Act, remain in place today. The extent to which sex workers are still seen as vectors of disease today is more difficult to measure and identify than any policy or law. This perception of sex workers can be found in clinical interactions mentioned by respondents as well as in public health research. Terms such as “vectors for transmission” and “vector of disease” continue to appear in how sex workers are regarded.[7273] This perception frames the sex work as dangerous and malicious, furthering the notion that sex workers are morally inferior and only deserving of care due to their threat to the rest of the population.

Experiences of HIV Negative Sex Workers within HIV CoC

This study focuses on the experiences of HIV-negative sex workers because of the 706 respondents that disclosed their HIV status, only 4 reported being HIV positive while 686 reported being HIV negative and 16 did not know their HIV serostatus. For this reason, the results of this study focus on the experiences of sex workers that are not HIV positive or not aware of their serostatus and not on sex workers that are HIV positive, as a sample of 4 respondents is too small to draw any conclusions.

The respondents reported being involved in a range of different occupations within the sex industry [Table 1] and the majority of respondents had worked in more than one area of the sex industry throughout their careers. The majority of respondents, 83%, are currently working in the sex industry while 17% have formerly worked within the sex industry. The results of the quantitative, qualitative, document, and ethnographic participant observation analysis focus on how these HIV negative sex workers interact with more upstream interventions and programming within the HIV continuum of care, such as education, screening, outreach, specialized sexual health clinical encounters, and other prophylactic measures. In brief, this analysis found that not only did HIV negative sex workers have many complex interactions with HIV services, but that many aspects of these interactions were shaped by their involvement in the sex industry.

The Relationship Between Sex Workers and Healthcare Providers

In reporting their histories within the HIV continuum of care, respondents discussed many aspects of hesitation surrounding disclosing their involvement in the sex industry to their providers. In a variety of settings (walk in clinics, PCPs, screening events), 58.3% of respondents reported that they did not disclose their involvement in the sex industry to their providers and 41.7% of respondents did disclose their status as sex workers. This aligns with results of community-based research among transgender sex workers; the majority of sex workers choose not to disclose their involvement in the sex industry.[74]

Respondents cited many reasons for choosing not to disclose their status as sex workers, the most frequent being: 1) Fear of receiving judgment from providers, 2) Fear of receiving lower quality treatment from providers, and 3) The belief that their status as sex workers was unrelated to their health concerns. Many respondents also stated that they disclose that they are a sex worker to some healthcare providers, but not others. As stated by respondents ages 23 and 40, 29, and 31 respectively, on whether or not sex worker status was disclosed and the quality of care they received:

> Yes and no. At the end of the day I don't want to be subjected to others opinions on my work and possibly be subject to discrimination so I keep it to myself.

> No, the times I choose to not disclose my job, the doctors have been nicer and much less awkward.

> PP once treated me poorly after I disclosed being a sex worker. I'm hesitant to attract that type of attention in a clinic setting.

> A few practitioners were passively disapproving, their affect changed after I disclosed

Lower quality care after disclosure includes judgmental comments, harsher tone and language, and uncomfortable questions for the sex worker seeking care. Many respondents also reported hesitation to disclose for fear that their provider would attribute medical concerns of the patient to sex work when the respondent believed the concern was unrelated to this work. Sex workers surveyed noted that it would be helpful to be able to provide physicians and other healthcare workers with a more complete view of their life and occupation, but that in many circumstances it was not worth the risk of altered, inferior treatment after disclosure.

Disclosure and Legal Repercussions

Another frequently reported reason for not disclosing sex worker status was the fear of facing legal repercussions, primarily having ones children taken away, after being reported as a sex worker by medical providers. A respondent age 30 states:

> However I would never tell them I am a sex worker for fear that they would report me. They are my children's doctor too. We fear being exposed as sex workers and the state trying to take our children.

As shown by many reports on the status of sex workers in the US, fear of legal consequences influences decisions in all areas of life.[75] Due to the criminal status of sex work, disclosing involvement in the sex industry, particularly escorting and street-based work, can lead to direct legal repercussions. The legal prosecution sex workers fear includes arrest or fines for them personally and also being found unfit parents and

having their children taken away. Respondents discussed being unsure of how their healthcare providers will or are obligated to report them, and this uncertainty brings about an even greater unwillingness to disclose.

Respondents who disclosed their status described that they only do so in settings they feel they will not be judged or reported. Gauging what the reaction of the provider will be was described as an unreliable task, except for in the cases that providers advertise that they are sex worker-friendly. A respondent, age 31, clearly articulated what must be in place in a healthcare setting in order to disclose:

> One in particular was great, but that was specifically because I sought a therapist who was sex positive and who worked with people in the sex industries. Unless a therapist identifies as sex positive, and declares on his/her website that they work with sex worker populations, there is no way that I would volunteer that information now. There is too little understanding about it, and I would be judged.

Respondents who did disclose their status chose to do so in order to give their healthcare provider a more complete picture of their lives. As with any other occupation, they wanted to be able to share with their provider the details of their life so that their provider could understand them and their health needs better. Even when health concerns were unrelated to sex work, respondents noted that being able to disclose their status could lead to stronger relationships with their providers and overall improved healthcare than if they didn't disclose.

Income Verification

Another frequently cited area of disclosure is income verification, which is an initial step in receiving treatment at many sites. Due to the criminal status of sex work, many respondents reported that they are unable to report their income for fear of being reported as a sex worker and prosecuted, so they are unable to verify their income to receive comprehensive HIV services. In settings where HIV care is free or subsidized, income verification did not cause the same tension is in other settings. However, the inability to verify income contributed to overall tension and reluctance in seeking and maintaining regular healthcare.

Discrimination Against Sex Workers in Healthcare

In discussing their hesitation to disclose to their provider, many respondents cited a fear of being shamed, judged, pitied, infantilized, and treated disrespectfully by providers. This experience was brought up again and again and healthcare providers' judgment appeared in many ways during healthcare encounters. Forms of judgment respondents perceived during clinical encounters include rudeness and dismissiveness after sex worker is mentioned. Respondents ages 27, 40, and 53 respectively also had clinical experiences that included:

> Mannerisms and demeanor portrayed as disgust or disdain for our profession.

> Asking inappropriate questions or noting things in my charts that had nothing to do with the visit like over-use of make up or dressed in sweats but wearing make-up. Asking if I was homeless, asking how much drugs I did.

Treat[ing] me like a child or a broken person.

These forms of discrimination against sex workers regarding how they are treated within healthcare are born out of the stigma against sex workers discussed by the sex workers rights movement. The presence and nature of stigma against sex workers is more difficult to measure than discrimination against sex workers, as stigma is a negative stereotype or perception and discrimination is the behavior that results from this negative stereotype. Discrimination can be more easily measured within healthcare and quantified in examples such as the ones shown above. However, this discrimination is born out of stigma that may be more widespread or take different forms than what is measurable through tracking stigma in clinical encounters.

Respondents also reported providers making many assumptions about the patient, rather than asking for clarification after hearing about involvement in the sex industry. Such assumptions include assuming that the patient was being abused, coerced, or forced, that the patient did not practice safe sex, that the patient had substance abuse issues, and that the patient did not understand their own health needs. In this way, discrimination also appears as healthcare providers failing to take thorough medical histories and making unfounded assumptions about patients because they work in the sex industry.

Moralism and HIV Care

Respondents noted that moral judgments on the part of providers often occurred after disclosure. One respondent 40, states, “[d]on't let your personal idea of morality get in the way. Just because it looks ugly to you does not mean what we do is bad and

we need to stop." In this response and many others, morality appears in how providers conceptualize and react to patients' involvement in the sex industry. Modern sexually transmitted infection (STI) interventions are born out of this notion that STIs are retribution for sexual deviance. While sexual immorality is now framed very differently than when this society is founded, respondents note that the notion of sex work as immoral remains within healthcare. Whether or not morality is explicitly states as an issue within clinical encounters, respondents describe how they are consistently aware of their providers' sense of morality. Respondents report feeling valued less and perceiving that providers think they are displaying harmful and shameful behavior after the disclosure of their status as sex workers.

Another concept discussed by respondents that is founded in the history of sexual immorality discussed earlier is the notion that sex workers are vectors of disease, primarily STIs such as HIV. Respondents report feeling as if they are being treated as vectors of disease within healthcare settings, and one respondent 34, writes a sentiment echoed by many other respondents, "We are not vectors of disease. The exchange of money does not make our work more of a public health risk than non-sex-workers who have multiple partners."

Sex Workers and HIV Prophylaxis

Condom Use Among Sex Workers

In opposition to this image of the sex worker as a vector of disease, many respondents reported a number of prophylactic measures to avoid contracting or spreading STIs. Prophylactic measures such as condom use, PrEP use, screening of

partners, and early detection of STI strategies such as frequent screening were discussed in the survey.

Table 1: Condom Use Among Sex Workers Surveyed

Condom Use While Working		614	86.4
	Never	58	9.45
	Rarely	28	4.56
	Sometimes	50	8.14
	Most Often	119	19.38
	Always	358	58.31
	No Access to safe-sex materials	1	0.16
Condom Use While Not Working		680	95.7
	Never	138	20.29
	Rarely	109	16.03
	Sometimes	145	21.31
	Most Often	159	23.38
	Always	128	18.82
	No Access to safe-sex materials	1	0.15

While working, the majority of respondents used condoms while working, although this question surveyed sex workers across different types of sex work, and many respondents are not providing services in which condoms could be applicable [Table 1]. While not working, a lower percentage of respondents used condoms but the majority of respondents used condoms always, most of the time, or some of the time. This percentage of sex workers that use condoms both while working and not working is higher than the national average. In 2017 the CDC reported that 14.8% of women and 19.0% of men aged 15–44 used a condom “every time” and 23.8% of women and 33.7% of men aged 15–44 used a condom at last sexual intercourse in the past 12 months.[76] In this way, the instance of condom use at all times while working among sex workers in more than three times the national average, and while not working is similar to the national average among men and greater than the national average among

women. Condom use some of the time is also greater among sex workers than the general population.

There are many reasons sex workers may use condoms more frequently than the general population such as economic stability being contingent upon good sexual health, increased awareness of topics in sexual health through discussions within the sex industry, and many others. Publications by sex workers describe how they often serve as sex educators for their clients and that the criminalization of both sex work and HIV transmission necessitates that sex workers are additionally precautious and open about their sexual health practices. In exploring this dynamic Cyd Nova, a sex worker and harm reduction activist, writes:

> Sex workers never doubt that we can be thrown in jail for diseases transmitted or not. Because the sex we have is paid for, it becomes available to scrutiny of all. The transaction is assumed to be dangerous from the beginning, leaving us in constant jeopardy of being accused of being a vector of disease, with the only salvation laying in the arms of being a "good whore." The laws that target sex workers for HIV go beyond incarcerating individuals. They reinforce a story that we are dangerous, need to be managed, medicated, legislated, and our bodies rendered safe to the so-called general public.[77]

This pressure to be a "good whore" may contribute to the many safe sex practices that sex workers engage in that people not involved in the sex industry may not be aware of or feel are necessary. A law that complicates condom use for many sex workers is the condom as evidence law. This law allows for more than three condoms on a person's body to be used as evidence that they are carrying out prostitution and grounds for an

arrest. This law has led to the arrest or many sex workers in addition to people that are not sex workers but are stopped and found to be carrying condoms. As reported in a study of 25 transgender sex workers, 20% of respondents feared carrying condoms. One trans woman wrote on her survey: “I have been told that if I had more than three condoms that was a sign of sex work. I told the police I'd rather be safe than sorry. That really didn't mean anything to them.”[78]

This policy dissuades sex workers from carrying condoms for fear of being arrested if searched and the condoms are found. This policy makes it more difficult for sex workers to engage in safe sex and avoid contracting HIV, and this policy stands in direct opposition to harm reduction practices in preventing HIV. Campaigns by rights-based groups carrying out harm reduction work in San Francisco and New York City have been successful in overturning this law, but in practice the police continue to undermine sex workers’ safety with impunity even after these intensive campaigns to end the use of condoms as evidence and to improve police/community relations. The ongoing policing of trans bodies exists independently of policy reform and the laws currently in existence and HIV prevention tools such as condoms are still being seized.[79]

PrEP Use Among Sex Workers

Within this sample, some respondents also used PrEP as prophylaxis for HIV with 8% using PrEP and 92% not using PrEP. The percentage of the US population on PrEP is roughly .03%, making the percentage of sex workers using PrEP over 250 times greater than the general population.[80] However, of all of the respondents only 59% had previous knowledge of PrEP and 41% respondents had no prior knowledge of

PrEP or its ability to prevent contracting HIV. For many respondents, access to PrEP knowledge and the drug itself served as the main barriers to consistent PrEP use. In broader HIV care, PrEP has been a large focus of prevention efforts since 2015, but many sex workers feel that other areas must be addressed before PrEP will ever be used consistently. A respondent of the "Nothing About us Without Us" report released by sex workers rights organizations states:

> A big struggle to access the quality, rights based health services we need and now there is a lot of talk about PrEP and Truvada. It is a distraction from what will be effective. If you don't have the money then you cannot access these new medications. They are not solutions for us.

As reflected in this sentiment, PrEP may provide protection from HIV infection, but many sex workers are faced with more pressing issues that prevent them from prioritizing or having a desire to use PrEP. For sex workers that cannot access safe housing, food, and other basic needs, PrEP is of little importance and until stability can be established in other areas of life. Additional concerns on the side effects of PrEP also deter PrEP use. As healthy, seronegative individuals, many sex workers do not want to introduce the risk of significant side effects when they are able to take other measures to prevent HIV infection. Outside of the United States, sex workers right organizations have expressed concern that PrEP will become mandated for sex workers in the way the HIV screening often is, despite the preference of the sex workers themselves and the ensuing side effects.[81] Sex workers rights groups also fear that PrEP use could be used as evidence for sex work and grounds for arrest in the way that condoms are. PrEP

remains a fairly new technology and as a key population sex workers remain an ongoing part of discussions surrounding PrEP nationwide.

STI Screening Among Sex Workers

In addition to condom and PrEP use, STI screening was a regular part of preventative measures for many sex workers. Respondents were actively involved in screening for HIV with 35% getting tested every 3 months or more frequently, 25% being testing every 6 months, 22% being tested once a year, 11% being testing less than once a year and 6 never been tested or having no access to testing. In comparison, the CDC reports that in the United States only 45% of the population has ever been tested for HIV. [82] HIV testing itself may not prevent HIV infection, but through testing it is possible to identify HIV infection early, receive HIV care, and prevent the spread of the infection.

The largely increased incidence of sex workers getting tested for HIV compared to the general public reflects the heightened awareness among sex workers of sexual health issues and precautions to take to protect oneself and others. Through these precautions, sex workers are actively protecting both themselves and their clients and partners in a more intensive way than the general public. These practices reflect the necessity discussed by Cyd Nova of being a “good whore” and fitting the narrative of a sex worker that takes all possible precautions to avoid STI acquisition and transmission. These practices suggest that sex workers may have knowledge and experience practicing safe sex that could be shared with other communities and that sex workers could serve as sex educators and safe sex ambassadors, as Nova describes doing in Australia.[83] However, this narrative leaves out the barriers that sex workers in the US

face in accessing these HIV prevention services. As a former sex worker and current public health professional Nova writes:

> This narrative requires that there is only one kind of sex worker: a person who has the opportunity to prioritize their sexual health while working, but I knew that there are many who did not. By this time, however, I had learned that public health doesn't like complications and has little room for the complexities of people's actual experiences. Public health wants to categorize people as high or low risk and decide whether or not they deserve program funding based on that categorization. It's a precarious system of social services administration that keeps people surviving just enough as to not be accused of gross negligence.

This statement reflects many of the experiences within the HIV CoC described by respondents in this study: current interventions do not fit with the complex and varied experiences of people working in the sex industry. Respondents reported a wide range of reasons that caused them to be for or against various sexual health decisions such as testing, condom use, and PrEP use, and blanket practices policies for all sex workers did not take into account these complexities.

Separating Risk of Labor from Risk Arising from Discrimination in Other Sectors

In describing these complex experiences within the sex industry and HIV continuum of care, many respondents wrote about their life circumstances being reduced to natural outcomes of their involvement in the sex industry alone. Respondents wrote about the struggles they face that are unrelated or occurred before they began doing sex work being attributed to sex work and stressed the importance of

not making assumptions about sex work and its impact. Additionally, respondents emphasized the importance of distinguishing between the risks of sex work itself and the risks and difficulties in many areas of life due to discrimination against sex workers. Through understanding this distinction it is possible to obtain a better understanding of why the experiences of sex workers within the HIV continuum of care were so different from the experiences of the general public. On this subject one respondent age 34 writes:

> Just listen to what your patient has to say, try to understand / figure out what your patient is saying they need rather than assigning what you think they need to them. Sex workers are the same as other people seeking help. They will have job related specific issues, as everyone does, but are individuals.

Other respondents echoed similar sentiments, that sex workers have health issues that may not be directly tied to escorting, stripping, camming, performing in porn, or working as a street based worker. For many respondents, their health concerns and experiences getting care were closely tied to their status as criminalized and stigmatized due to their job but were not necessarily tied to the labor itself. The framing of sex work as labor and not as moral degeneracy or the entirety of a sex worker's identity aides the process of separating health concerns tied to sex work from other health concerns sex workers may have.

Pressure to Exit

Respondents also reported experiencing a pressure to exit the sex industry from providers after disclosing sex worker status. Respondents discussed healthcare

providers, particularly therapists or counselors, immediately blaming struggles on involvement in the sex industry and pressuring the respondent to exit the industry. As one 53 year-old respondent writes:

> I wouldn't dream of telling a therapist what I do for work because I know that, despite the fact that mental illness runs in both sides of my family and I've been treated for mental illness since childhood, I'm sure I'd have to deal with some moron trying to blame my job for my mental state, when in reality it's probably the only reason I haven't killed myself yet.

While many respondents had exited or had wanted to exit the sex industry at various points in their life, this pressure from healthcare providers came at times when they were not interested in exiting. As described in the introduction, consensual sex work is increasingly conflated with sex trafficking and work in the sex industry that involved force, fraud, or coercion. Respondents described experiences with providers in which providers assumed the respondent was a victim of sex trafficking. Other respondents describe scenarios in which healthcare providers understand that the respondents was not a trafficking victim, but that it was assumed that sex work was the root of health problems and that any form of healthcare would only be effective if the respondents exited the sex industry.

Lack of Training

A final way many respondents saw themselves treated differently within the HIV continuum of care and broader healthcare is in the lack of training providers have in caring for sex workers. Training can be defined very broadly in this sense as a

readiness and preparedness to care for sex workers; not necessarily a different set of practices but rather a comfort in understanding the position of a patient who is a sex worker and how a provider might care for them best. Respondents reported clinicians and healthcare staff becoming flustered or unsure of how to proceed when sex work is mentioned and proceeding with medical coding or procedures that are unrelated to the respondents initial concerns in seeking healthcare. This lack of preparation and training in treating sex workers ties into all other differences sex workers experience that have been mentioned above. Never being exposed to discussions surrounding sex work or the perspectives of sex workers allows for sex workers to be easily othered when encountered within the HIV CoC. Providers that have never engaged in conversations surrounding sex work may easily make moral judgments, assumptions, and biased decisions for their patients. The differential experiences compared to the general public that sex workers face within the HIV CoC is integrally tied to the perspectives and preparedness of healthcare providers to care for sex workers. Many of these perspectives are rooted in more general stigma and treatment of sex workers, and this discrimination that happens outside of healthcare is often what exacerbates health concerns and leads sex workers to the HIV CoC.

Chapter 2: HIV Continuum of Care as an Entry Point to Broader Healthcare Services

Within the survey administered by COYOTE RI, sex workers also discussed their experiences with broader healthcare and not simply HIV care. Respondents touched upon their various health needs and how they felt these needs were or were not being met; however, STI testing and care remained central to many of the personal narratives presented about disease and healthcare. HIV and other STIs are a key part of how sex workers are regarded in and out of healthcare and this chapter looks to examine how this framing of sex worker healthcare through STI care is constructed and how it impacts sex workers. Accessing healthcare, particularly primary care, is a challenge for many people living in the US and this chapter explores the ways in which perceptions and criminalization of people working in the sex industry further complicate healthcare experiences.

Barriers to Accessing Primary Care Directly

Within the United States, consistent and high quality healthcare is not accessible to large portions of the population.[84] Patients that are uninsured and unable to pay out of pocket for care experience long wait times and irregular care at free clinics and many people living in the US do not seek care until their medical conditions are dire.[85] . In the United State, 28% or men and 17% of women do not have a primary care doctor and these percentages are even higher for populations that experience marginalization along the lines of class, race, gender, and sexual orientation.[86] The sex workers surveyed in this project cited the high cost of many medical services and the inability of respondents to pay for consistent primary care as primary barrier to accessing

healthcare. Convenience also played a role in not being able to access healthcare, as respondents noted that free clinics were available but have long wait times and providers were not consistent. Of the sex workers surveyed, 30% were uninsured and therefor only able to access healthcare through covering the entire cost themselves or going to free clinics.

Additionally, fear of discrimination or judgment within healthcare prevented many respondents from seeking healthcare. Participants cited poor treatment within healthcare, or at a particular location, in the past and an inability to find a new provider they could access or trust as a significant barrier. An additional barrier is the lack of clinics and practices that respondents were sure would provide effective care that was judgment free and addressed the health needs of sex workers. Within this sample of sex workers, 70% did not report having seen a primary care doctor while working in the sex industry.[87] This alarmingly high percentage indicates that the majority of the sex workers surveyed in the research did not have any form of comprehensive of consistent medical care.

HIV CoC as an Entry Point to Healthcare

An experience many respondents touched upon within the COYOTE RI survey was accessing broader healthcare services through STI screening and prevention services. In describing the healthcare they sought while working in the sex industry, 49.6% reported seeing a healthcare provider for STI tests, while only 29.7% reported seeing a primary care physician or attending check-ups at a clinic. In other realms of healthcare, 47.6 % or respondents sought mental healthcare and 8.1% had visited the

emergency room while working in the sex industry [Appendix 1, Table 2]. In this way, STI screening is often the first or most frequent point of contact that sex workers have with any form of healthcare.

Respondents did not engage with other critical areas of healthcare such as primary care, mental healthcare, and obstetrics and gynecology as frequently as they engaged with STI services. The ways in which broader care was accessed through STI services vary but the description of this practice by one respondent age 35, echoes the sentiments of many respondents:

> I get tested whenever I can use the test to get my foot in the door of a clinic. I'm not very sexually active at all but I can't afford health care for numerous problems I do have. I have noticed however that most clinics will provide free STD testing and, once you are in the door, you can ask the doctor about other problems you're having or play dumb and claim you thought your other problems were related to a possible STD.

This experience highlights the fact that the HIV CoC focusing on disease prevention and screening may be more accessible than primary care or other forms of healthcare for many sex workers. For some respondents such as the respondent quoted above, accessing healthcare beyond STI services took the form of asking additional services of the provider screening them for STI. For other respondents, accessing healthcare through STI services meant using STI clinics to learn more about healthcare options that were feasible for them outside of the clinic. STI clinics that provided information of primary care or mental health services that were close, accessible, and accepting patients were able to connect respondents with broader healthcare services.

In discussing disclosure of sex work, many respondents noted that they disclose their involvement in the sex industry to providers administering STI screens or STI treatment, but not to their primary care provider. Participants reported that while they experienced discrimination in the HIV continuum of care, the discrimination they faced in other forms of healthcare was more frequent and interfered with more with care due to the larger assumptions being made. Although the priorities of sex workers may not be HIV services, the presence of HIV services as well funded and visible places for sex workers to go may also contribute to the HIV CoC serving as an entry point to other forms of healthcare, or other services and support systems outside of healthcare.

Funding Healthcare for Sex Workers

Among healthcare services designed to the needs of sex workers, there are far more programs, initiatives, and clinics focusing on HIV and STIs than on primary care and other forms of healthcare. In the United States there are two primary care clinics, St. James Infirmary in San Francisco and the PurpLE clinic in New York, which provide and widely advertise healthcare services for sex workers outside of STI care and screening. This study does not count and catalogue the number of programs, initiatives, and centers focusing on preventing, screening, and treating HIV among sex workers but it is an area that is given priority within the field of HIV due to the nature of sex workers as a key population. Programs funding biomedical work with or research on key populations are emphasized within HIV funding streams; however, this work is often in contrast with the immediate needs of sex workers.

At the AIDS 2014 conference, sex workers gathered and produced a series of consensus statements regarding sex workers and HIV at pre-conference events. These statements addressed how sex workers continue to be viewed and treated as vectors of disease, and how the design and funding of programming working with sex workers is often strictly biomedical. Some of the primary statements from sex workers addressing how interventions that operate through a biomedical framework dominate programming that serves sex workers include:[88]

1. Biomedical responses are often imposed without thought of the workplace health and safety of sex workers, which need to be considered before implementation.

2. Sex workers are being forced to engage, without consultation, without adequate information so we can choose if and how it can benefit our community. Sex workers face pressure from governments to be tested and pressure from clients who want workers to use PrEP in place of existing safe sex practices.

3. New approaches don't meet the needs of sex workers, we need to maintain and increase funding for sex worker led community programs

4. Legal barriers for sex workers are still so significant that unless we resolve those issues first, through the full decriminalization of sex work, test and treat or treatment as prevention are abstract concepts that have no meaning for sex workers but will divert resources away from approaches that we know work

These consensus statements touch upon the fact that the HIV CoC is often what is most available to sex workers, but is not necessarily what they need. Rather than condemn these biomedical interventions, these statements highlight the fact that many other areas of sex workers rights must be taken into account and upheld before biomedical practices and technologies specifically focused on sexual health are effective. In considering health as a human right, sex workers should be able to access healthcare that maintains all areas of health, not simply sexual health. Connecting with other forms of healthcare through STI services allows sex workers to care for all realms of health; however, it is also important to examine why sex workers are not accessing primary care services directly. Difficulty in accessing general healthcare is not a difficulty only sex workers face, many people in the US do not receive consistent healthcare; however, there are specific ways in which sex workers face additional challenges in accessing care. The continued presence of the notion that sex workers are vectors of disease contributes to healthcare programming for sex workers being focused solely on STIs. Healthcare providers outside of the HIV continuum of care could better serve sex workers through not necessarily focusing their care solely upon sex workers but through ensuring sex workers know they will receive care without assumptions being made based upon their work.

Chapter 3: Defining and Constructing Sex Worker Inclusive Care within the HIV Continuum of Care

As discussed in Chapters 1 and 2, there are many ways in which sex workers receive a lower quality of care within the HIV CoC than the general public. The experiences provided by respondents indicate that stigma surrounding sex work permeates through many levels of the HIV CoC, from the structure and methods of HIV care systems to interpersonal interactions with clinicians. Despite this widespread stigma, respondents were able to imagine alternatives to current healthcare and HIV care that provides more effective and compassionate care for sex workers. As sex workers that face stigma and policing in many other areas of life, respondents saw the HIV CoC as a site where tangible changes could be made within current systems to better uphold the rights of sex workers. Health is an essential human right and many of the suggestions respondents provided come from rights-based work in sectors such as education or migration. Suggestions provided in this study would reframe how the rights of sex workers could become the basis of any form of healthcare.

Sex workers rights organizations have also conducted research and published suggestions on how sex workers could receive a higher quality of care within the HIV CoC. I key example of this is the “Nothing About Us Without Us: Sex Work, HIV Policy Organizing, and Transgender Empowerment” report conducted by the Prostitution Policy Report and the Desiree Alliance, which provides comprehensive recommendations for how to address the HIV needs of trans sex workers [complete list of recommendations can be found in Appendix 4]. These organizations look to other rights-based movements for more complete analysis and suggestions that would uphold the rights of sex workers. A policy report published by the Best Practices Policy Project

and Desiree Alliance suggests that sex workers can learn from and should work in solidarity with racial justice, economic equality, and immigrant rights movements. Understanding the work of these movements not only provides tools for better upholding the health of sex workers, but also acknowledges the intersection of transphobia, whorephobia, HIV stigma, racism, and ableism and allows it to be taken into account in any future recommendations or work. Similarly, the analysis of suggestions made by sex workers in this study looks to understand the complexity of what sex workers need to maintain their human right to health within the HIV CoC.

Isolation and Healthcare as a Site of Intense Trust/Mistrust

When discussing their experiences within the HIV continuum of care, many respondents brought up how healthcare can be an area of intense trust and support or one of the strongest areas of mistrust and anxiety in their lives. As mentioned earlier, the majority of respondents did not feel comfortable disclosing the nature of their work with providers for fear of being discriminated against. Respondents fear being outed in other areas of their lives and often heighten their vigilance and skepticism in healthcare settings because such personal information is often requested. However, due to the personal nature of many clinical encounters respondents also shared how that they sometimes felt able to share details of their life with their healthcare providers that they were unable to share with other people. One respondent 35, writes, “please understand that you are probably the only person they can go to and the only person aware of these situations.” Clinical encounters provide an intimate opportunity for many respondents to build trust and find support in someone they feel will care for them. Another respondent, age 36, writes:

> Just being able to disclose that I was engaging in commercial sex could have been invaluable. I was completely isolated socially, and didn't believe I could trust anyone with what I was living through.

The ability to place trust in healthcare providers provides social support that is often lacking in other areas of the respondents lives in the presence of widespread stigma against sex workers and criminalization of sex work. Respondents described how healthcare can serve to alleviate social isolation if the patient feels comfortable working with their healthcare providers.

Avoidance of Services for Fear of Being Reported or Surveilled

Through the same reasoning, many respondents described feeling further socially isolated when not able to communicate properly with their healthcare providers. Two respondents ages 34 and 21 respectively describe how this fear of being shamed prevents sex workers from seeking out healthcare:

> Please keep your opinions to yourself and remember the passion for helping people that I assume is part of what drove you into the medical field… Quite a lot of us have been through so much as it is it's hard enough to find the courage to walk in your office in the first place.

> Just be nice to us and understand that we deal with an unbearable amount of judgment and stigma already and cannot handle anymore side-eyeing or uncomfortable questions or unsolicited condescending advice. I don't want a

> lecture, or your pity. I'm just here for medical care. Please don't make it any harder.

Respondents describe a fear of being reported or prosecuted in the future after disclosing to their provider and choose not to for this reason. A respondent, age 22, shares:

> Even if you get an understanding medical professional, I don't want my sexual health and history to be part of some permanent record that shows up for future professionals who might be less understanding.

Other respondents fear that their children will be taken away, they will be arrested, or they will be further stigmatized in their lives outside of a clinical encounter if they disclose. For this reason, many respondents emphasized the important of keeping sensitive information confidential within healthcare. They additionally recommend that providers not put incriminating information about sex work on file as to prevent difficulties for the patients in the future.

Ability to Disclose Involvement in the Sex Industry

Many respondents shared the sentiment that they would like to be able to disclose their involvement in the sex industry to their healthcare provider. One respondent 18, expressed a thought repeated by many that, "A doctor can't do their job if you don't disclose something so connected to your health." In clinical encounters, especially with clinicians that a patient sees regularly and gets to know, it is expected that the healthcare providers know the occupation of their patient. With any other form

of labor, the work a patient does is noted and used to provide a complete medical history and understanding of a patient's experiences. However, many sex workers choose not to disclose for fear of discrimination and their providers are left with a very incomplete picture of their patient's life.

Of the sample, 45% thought the ability to disclose sex worker status would improve the healthcare they received, 30% thought it depends on the situation, and 25% thought it would not improve care. As one respondent, ages 32 and 38 respectively, write:

> I have disclosed my status to multiple providers. Only once did I feel it increased the quality of care I received. I disclosed to a health care provider during STI testing. She responded very positively. I was able to ask her questions regarding safer sex practices and testing that were specific to sex work and how I work. It was great and extremely useful. Other times I have disclosed, I felt it decreased the quality of care I received, because the provider was whorephobic and giving care from a place of stigma.

> The ones I have disclosed to I had seen regularly and knew they would be helpful. It gave me less anxiety knowing they knew and I didn't have to make up a story of why I wanted another STD test.

In this way, the respondents thought the quality of care could improve when disclosing, but only if the provider did not shame or judge them for working in the sex industry.

Respondents shared that there are some healthcare scenarios in which they feel more comfortable disclosing than others. A respondent age 25 describes the only scenario in which they was disclosed:

> It was one of the routine screening questions they asked me, non judgmentally (ie do you have sex with men, women or both? Have you had sex for money or other needs...). I felt comfortable disclosing *because they asked*. This is rare.

Another respondent age 36 writes:

> I think if medical professionals were educated further on the issue and industry, as well as some sensitivity training on engaging in a genuine and non-judgmental way, it [disclosure] could be invaluable. As the current stigmas and ignorance that exists among the general public, I don't know that it is generally helpful for sex workers to disclose.

The majority of respondents felt disclosing in particular situations could be very beneficial, and potentially necessary, for them to receive adequate health; however, much work needs to be done on the part of providers before sex workers will feel safe disclosing.

Non-judgmental Care

In describing what healthcare providers can do to make their care more effective and supportive for sex workers, many respondents discussed wanting to be **listened to, treated the same as other patients, and the care they receive to be based on fact and not assumptions**. Respondents stressed the important of healthcare providers

acknowledging a sex work history if it's disclosed while also gathering a complete medical history and not using involvement in the sex industry to make assumptions about the respondents health. In describing what more effective and sex worker friendly care would include, respondents ages 34, 35, 29, 25, 30, and 23 respectively write:

> Be patient if a sex worker tries to tell you their story because it signals that they are beginning to trust you. If you cut them off or act indifferent you will crush that trust, and you may not get another chance to regain it. Don't rush to conclusions.
>
> Slow down. My body is very very important to me, even if you think otherwise by my actions. I am here. I care. Treat me. Like a person.
>
> When you reduce us to our job, then you contribute to our poor mental health.
>
> Sex workers need to be listened to and respected, our jobs do not impair our ability to know ourselves and we are not in need of rescue, simply more options.
>
> To help sex workers deal with the issues that come with sex work without making the actual sex work job an issue to be fixed.
>
> Treat us like any other patient, but with unique needs (that should not be stigmatized) due to the industry we're in."
>
> Treat us like humans. Don't make assumptions about who we fuck or how we fuck. If sexual info is necessary for care, ask using nonjudgmental, nonbiased language. A lot of us are trans, queer, survivors. Biased language hurts us.

In defining non-judgmental care, many of the respondents described care in which sex workers are not looked down upon for their choices and assumptions are not made about their health decisions due to their involvement in the sex industry. Sex worker friendly care includes language that is respectful of sex workers and treats sex workers as patients of any other occupation would be treated. Two respondents ages 34 and 30 write:

> The exchange of money does not make our work more of a public health risk than non-sex-workers who have multiple partners. We need well-informed providers who can non-judgmentally give us the information we need to elect which tests and services we need.

> Don't stigmatize sex workers. Don't treat them like victims, if it's a non-victim situation. Some sex workers love what they do and not everyone is coerced. Provide services that make women feel safe to ask for them and not feel ashamed

As illustrated by these responses and many more, one of the most significant ways in which healthcare providers can be sex workers friendly is through treating sex workers the same as their other patients. This includes acknowledging the realities and experiences of sex work itself and how it may affect health while avoiding basing medical decisions off of assumptions about sex work. Sex workers want healthcare that humanizes them and is respectful of their person and their health independent of their labor.

Sex Work-Specific Training

Respondents also highlighted the importance of healthcare providers putting in the work to understand the realities of sex work and unlearn many of their biases regarding sex work. This includes healthcare providers reading publications by sex workers, interrogating and working to break down their own stigma against sex workers, and participating in trainings that would allow them to discuss and understand how to provide sex workers friendly care as it has been described above. Three respondents ages 34, 42, and 31 share:

> We need our providers to do their own work processing and healing their own sexual wounding and stigma.

> I would tell them that they need to check their assumptions, their fears, and their privilege at the door. I would advise them to read peer reviewed research about sex work outlining clear methods of gathering data, and written by fellow sex workers. I would tell them to educate themselves on the various hierarchies within the sex industry. I would ask them to listen to sex workers and our concerns about ourselves, and meet us wherever we are. View us as people. Stop stigmatizing us.

> Educate yourself about specific risk patterns and awareness without stereotyping…make yourself aware of other practitioners who will provide non-judgmental care.

Sex work specific training would work to address many of the areas in which sex workers receive a lower quality of care through better equipping providers to work with

sex workers. Trainings that allow healthcare providers to interrogate and work to break down their own biases would allow sex workers to receive care that is not rooted in assumption and feel more comfortable seeking care.

Education for Sex Workers on Health Topics

In discussing the HIV CoC, respondents also discussed the importance of educating sex workers on sexual and general health topics. Respondents suggested that this education being focused on harm reduction through understanding the risks of particular behaviors or scenarios. It was also suggested that this information be easy to access in and out of clinical settings through clinicians, support staff in healthcare centers, and people working in other sectors. It is also important that this education emphasize the most important areas of healthcare and how to prevent STI infections and maintain health. One respondent, writes, “[Doctors] have no idea what you are doing when you say ‘lets have a conversation about your behavior.’ Just give me the information I need to survive.” The social isolation that sex workers experience due to stigma and policing frequently cuts them off from other critical education resources. Without educational tools surrounding health sex workers are left to teach themselves about health topics or try to survive without these tools. Education on best practices in sexual health and health in general would provide sex workers with the tools to care for their health that many sex workers currently do not have access to.

Areas of Support

Many respondents also stressed the importance of healthcare not being an isolated field but rather a support system for sex workers that is integrated into other support systems present in their life. These other support systems may be informal communities, families, groups of friends, or more official systems such as social services, educational establishments, or faith-based groups. One respondent, 54, suggests healthcare providers “offer outstanding resources if they know of any in the area and if it's needed.” Additional services may be in the form of financial support, education, support with substance use, or other resources that would make maintaining health, and life in general, easier. As described earlier, the HIV continuum of care may serve as a frequent entry point for sex workers into broader healthcare, as well as helpful resources more generally. Healthcare providers that had existing knowledge of other support systems sex workers could look to outside of the HIV CoC would allow sex workers to gain the support they need but were potentially unable to previously find. These additional areas of support in turn contribute to better health, as it is easier to maintain health when other basic needs are met and social support is present. Isolating the HIV CoC from other areas of a patient’s life makes it more difficult to access and return to and working with other support systems allows for the rights of sex workers to be more comprehensively upheld.

Chapter 4: Imagining Alternatives and Rethinking the Role of the HIV CoC in Upholding the Rights of Sex Workers

Within this survey, sex workers provide many suggestions for how to improve the quality of healthcare they receive, both within and outside of the HIV CoC. This project surveyed individuals working in any area of the sex industry in the United States; however, sex workers have organized for decades and this project also explores the recommendations of these sex worker lead organizations on how to improve the healthcare sex workers receive. Sex workers rights organizations call for sex work to be recognized as work and for the health of sex workers to be viewed as a fundamental human right and upheld as such. They put forward a rights-based approach to healthcare in which sex workers are treated with the same respect as any other patient and listened to by clinicians and healthcare policy-makers. A rights based approach acknowledges that health outcomes are dependent on areas outside of healthcare and healthcare is integrated into other social support systems. Within this approach, HIV healthcare is not treated as the exceptional sector for sex workers and education, housing, food access, and many other areas are also integral to this approach.

Reframing Programming for People Working in the Sex Industry

In considering how to break down stigma against sex workers within healthcare, looking to movements that have been successful in fighting stigma provides models for how this work could be carried out. The 2015 report “Nothing About Us Without: Sex Work HIV Policy Organizing” examines the experiences of transgender sex workers and provides recommendations on major issues that impact this community. Contributors write about the necessity to frame this work as fighting structural oppression and

"strongly advise that the nationwide movement resisting for racial justice could frame the issues raised in this report.[89]" Framing sex work organizing through the movement for racial justice allows for the treatment of sex workers today to be understood in the context of white supremacy in the United States as the foundation for various forms of stigma and violence. As discussed earlier in this thesis, the motivating factor to develop organizations curbing syphilis and gonorrhea by abolishing sex work was the desire to maintain "the race."[90] "The race" refers to middle and upper class white American nationals and through this framework it can be understood how racism, primarily anti-blackness, serves as a foundation for stigma against all sex workers. Additionally, the stigma that people of color working in the sex industry face is compounded by simultaneously experiencing racism, whorephobia, and their complex interactions. Framing sex workers rights as support for racial justice acknowledge many of the common goals shared by these two movements such as: ending mass incarceration, economic equality, and the breakdown of stigma rooted in white supremacy. Working within a racial justice framework also incorporates intersectionality theory and takes into account that sex workers of color are more harshly stigmatized and policed within the United States than white sex workers.

Other movements that address stigma and policing can also inform the work being carried out to uphold the rights of sex. Through framing sex work organizing as an extension of economic justice work, sex work is treated as valid labor in which exploitation must be prevented, as in any industry. Through considering the economic side of sex work, it becomes clear that many people work in the industry because other jobs do not pay a living wage. Eradicating poverty has been a fundamental part of US

sex workers rights movements in the past, and the call to "Outlaw Poverty, Not Prostitution," allows for the complex interactions between sex worker and economic inequality to be explored.[91] Fighting for the eradication of poverty would allow for people to not feel pressured to enter or remain in the sex industry to survive. Framing the difficulties sex workers face as a human rights issues allows for the fact that sex workers frequently experience multiple forms of oppression to be addressed.

Learning from the Sex Workers Rights Movement in Brazil

Sex workers rights movements from outside of the United States can also be used to imagine alternatives to the current experiences of people working in the sex industry in the United States. Rights-based organizations lead by sex workers outside of the United States are being carried out in a different context and do not experience the same legal constraints but share many of the challenges of United States-based movement face.[92] A prominent example is the sex workers rights movement in Brazil and their work in the healthcare sector. Sex work has always been legal in Brazil, although there are laws in place to prevent third party involvement in sex work, criminalizing brothels and women working in groups. The modern sex workers rights movement originated during the military dictatorship (1964 – 1985) when sex workers began protesting police brutality and wage theft targeting sex workers.[93] Sex workers began to participate in the efforts of The Women from the Favelas and Periphery *(Mulheres de Favelas e Periferia),* a coalition of women living in poverty and looking to improve their lives and their families' lives through collective action. In working with other women at the margins of Brazilian society, sex workers were included in conversations not only about the sex industry but

also poverty, racism, and misogyny that impacted these women. A Brazilian Network of Prostitutes was created in the 1980s and sex workers began to meet on a national level to discuss the work that they were involved in throughout the country.[94]

Davida

A particularly prominent organization that grew out of these efforts was Davida (*da vida* = of the life, living as a sex worker), founded in 1992 by Gabriela Leite.[95] Davida is based in Rio de Janeiro and looks to "create opportunities to strengthen the citizenship of prostitutes, through organization, defense and promotion of rights, mobilization, and social monitoring [complete list of objectives in Appendix 5].[96]" Davida's approach to achieving these goals is multi-faceted and looks to involve sex workers from across the entire country. Davida publishes *Beijo da Rua* (A Kiss from the Streets), a monthly newspaper written by prostitutes that discusses current events and issues relevant to sex workers. *Beijo da Rua* updates and builds community among sex workers and educates people outside of the industry about sex work.[97] Additional publications are put out through The Davida Center for Research [Núcleo de Pesquisa da Davida], a branch of the organization that conducts research in collaboration with Brazilian Universities that aim to support public policies on violations of the human rights of prostitutes.[98]

Davida sponsors the show *Mulheres Seresteiras* [women who sing], the Carnaval street parade *Prazeres da Vida* [Pleasure of the Life], and produces a clothing brand Daspu [*Das Putas* = of the whores] that hosts a famous yearly fashion show. These cultural areas promote community integration and reduce the stigma and isolation that sex workers encounter throughout Brazil. As a network of sex workers, Davida also

supports and provides tools to organizations that create peer-led interventions for sex workers in the form of clinics, community centers, education, or outreach programs.[99] Within healthcare, the Davida promotes preventative and accessible care for sex workers, including STI screening and prevention.

These diverse initiatives inform policy recommendations and advocacy campaigns Davida carries out that emphasize the safety and health of sex workers. For decades, Davida has been an active presence at a local, state, and federal level advocating for the rights of sex workers. The visibility and organization the Brazilian prostitutes achieved at precisely the time that AIDS was becoming a global concern contributed to the birth of partnerships with the then-forming social movement to combat AIDS, and shortly after, with Brazil's own Ministry of Health.[100] Through the Brazilian Ministry of Health, Davida has released a series of posters and other forms of media that publicize the Ministry of Health's support for sex workers as citizens. These posters, presented below, were released across the nation at the same time Gabriela Leite coordinated the production of the first manual of prevention of HIV/AIDS for prostitutes in collaboration with the Ministry of Health.

"Maria Sem Vergonha/Maria Without Shame"
Campaign by Davida and the Brazilian Ministry of Health, 2002[101]

Without shame of being a prostitute. Without shame, girl, you have a profession.
Without shame for fighting for your rights. Without shame girl, you have a profession.
Without shame for valuing your work. Without shame, girl, you have a profession.
Without shame about using a condom. Without shame, girl, you have a profession

As Brazil constructed one of the most comprehensive and effective HIV care systems within their federal healthcare the Sistema Única de Saude (SUS, The United Health System), sex workers from the Brazilian Network of Prostitutes, the First National Gathering of Prostitutes, and then Davida were integral to designing these care systems. In making healthcare recommendations, sex workers rights groups attempted to incorporate human rights outside of healthcare in nationwide interventions with sex workers. Leite writes, "This widening of the prostitute agenda beyond the subject of HIV/AIDS also questioned the underlying hygienist bias to an approach to prostitutes that restricted itself only to disease transmission, and contributed to the establishment of the concept of vulnerability as a guiding framework of the national response to STDs and AIDS.[102]" Vulnerability continues to frame HIV work in Brazil and sex workers have influenced many key decisions in Brazil's HIV CoC.

Sex Workers Rights in Brazil and PEPFAR's Anti-Prostitution Pledge

The dialogue between Brazil's Ministry of Health and the sex workers rights movement was strengthened in 2005 when the federal government took into consideration the Brazilian Network of Prostitutes and Davida's decision to refuse to accept PEPFAR funding that included the anti-prostitution pledge. Gabriela Leite writes at the time "I spoke with my colleagues who also had projects funded by USAID and we traced an extremely clear line of action: either they retracted this clause, or we would interrupt our projects.[103]" Gabriela's decision had the support of other segments of the social movement against HIV/AIDS, and drove the federal government to reject $48 million in USAID funding that would have been directed to give continuity to these organizations. Turning down PEPFAR funding meant fewer resources for HIV care but more importantly it made clear Brazil's dedication to listening to sex workers in making policy and funding decisions.

Davida has put forward other policy recommendations, such as decriminalizing third party involvement in sex work, but none have been as visible as Davida's involvement in HIV policy. Davida's prominence in the public eye allows for sex workers nationwide to challenge stigma against sex work on a large scale. In conceptualizing the work of sex workers rights organizing in any context Leite writes:[104]

> I always dreamed about and believed in a movement that would transcend barriers and reach all of society, all of it… A revolutionary organization has to always remember that its goal is not to make its supporters listen to convincing lectures by leading experts**,** but to make them speak for themselves, so they can reach, or at least exert themselves to reach, a place of political participation. When my whore

> friends were parading beautiful and proud [for DASPU], with no shame for being whores, they were speaking for themselves and being political, extremely politically revolutionary.

Leite herself ran for city council in Rio de Janeiro and although she did not win, has left a lasting legacy both in Brazil and internationally.

Sex Workers Rights in a Changing Political and Social Climate

The work of sex workers' rights organizations in Brazil provides an example of how grassroots efforts by sex workers can impact policy and perception of sex work. Many of Davida's programs do not have immediate, easily measurable impact but rather look to shift the way that sex workers are framed within Brazilian society and promote their rights in solidarity with other marginalized communities. However, recent political shifts in Brazil have lead to changes in the way Davida is allowed to operate while being federally funded. A 2013 workshop sponsored by the Ministry of Health brought together sex workers to create a series of posters that focused on breaking down stigma surrounding condom use and sex work. The poster featured photos of sex workers and quotes from the workshops such as "I can't stay without a condom, love," "every day we have to do AIDS education and prevention," "not accepting people the way they are is a form of violence," "the biggest dream is for society to view us as citizens," and "I am happy being a prostitute" [complete posters can be found in Appendix 7].[105] After the campaign was published in 2015, there was an immediate backlash within Congress, Brazil's Minister of Health Alexandre Padilha ordered that the poster reading "I'm happy being a prostitute" be removed from the Department of STD/AIDS, the head of Brazil's

Department of STD/AIDS and Viral Hepatitis was fired, and the campaign was taken off of the internet.[106]

This is one incident among many in which the previously holistic and rights-based programming addressing sex work within healthcare policy is being changed. Congress has cut funding for HIV programming, specifically peer-led programming for sex workers and initiatives that address stigma. These actions erase and hide populations that are inconvenient to current moral agendas, political ambitions for power, and the image that Brazil attempted to project of itself as a safe, clean and respectable for the July 2013 visit of the Pope, 2014 World Cup, and 2016 Olympic Games. Brazil's mega-events have come and gone along with many raids of and displacement from neighborhoods where sex workers live, but despite the ongoing work of Davida, the healthcare policy and increasingly negative public perception of sex workers in Brazil has remained. These rapid changes indicate how changes in policy and perception are often tied to factors outside of sex work and display the continued impact of beliefs surrounding sex work in the US and global north, which determine what is "respectable" for a city hosting international mega-events. In imagining how the rights of sex workers could be better upheld in the United States, looking to understand the successes and difficulties of international movements can serve as examples as well as provide support for sex workers in the United States.

Sex Workers and the Anti-Trafficking Industrial Complex

As in Brazil, policy that affects people working in the sex industry and perceptions of sex workers have undergone an immense shift in recent years in the United States. This

transformation has been due to the increased concern surrounding sex trafficking in the United States and a nationwide desire to put an end to sex trafficking domestically and abroad. Sex trafficking has been discussed throughout this thesis as a form of exploitation that exists worldwide and is defined as involvement in commercial sex work due to force, fraud, or coercion, or the involvement of a minor in the sex industry. Sex trafficking is fundamentally different than consensual sex work in that trafficking is a form of exploitation and sex work is a form of labor. The fact that sex work is often chosen due to lack of other options complicates this dynamic, but within various economic constraints sex work may not be the ideal form of labor but will allow for someone to support themselves. Sex work has long been considered morally reprehensible and universally exploitative in the United States; however, for many people working in the sex industry it is an exchange of services for money or goods that is no different than any other industry they have worked in. Exploitation such as wage theft or unsafe working conditions may be present within the sex industry, but if sex workers are electing to work in the sex industry than they are not victims of sex trafficking. Sex work is one of the only forms of labor in which if workers are not satisfied and happy 100% satisfied, it is not considered valid labor.

In 2000, the United Nations published the Palermo Protocol, which focused on preventing, suppressing, and punishing trafficking in person and serves as a foundation for policies that would be put in place globally to address trafficking. Within the United States, hundreds of news laws have been introduced on both a state and federal level to end “modern-day slavery [additional information on legislation in Appendix 8].[107][108] Additionally, dozens of large organizations have formed to put an end to human

trafficking and private citizens have been called upon to do their part in ending trafficking. The urgency to address "modern-day slavery" has resulted in the creation of a human trafficking rescue industry in which interventions have increased criminalization and surveillance of sex workers and undocumented migrant workers, and an appropriation of low wage women's labor in new markets for "slave free goods" has arisen.[109] Human trafficking as a global issues has united unlikely bedfellows including radical feminists and evangelical Christians, as well as state and private sectors. Much of the work being done to combat sex trafficking involves spreading awareness about trafficking and media campaigns make up a significant and very visible part of this industry.

The intensity and extensive reach of the sex trafficking narrative have reframed mainstream perceptions of sex workers. Within this framework, all sex workers are victims in need of saving and ensuing interventions focus on rescuing and rehabilitating victims of sex trafficking. Earlier this year, the United States Congress passed additional legislation to strengthen anti-trafficking programs that has already impacted the working conditions and lives of US-based sex workers. The Stop Enabling Sex Trafficking Act (SESTA) passed in the Senate and Allow States And Victims To Fight Online Sex Trafficking Act (FOSTA) passed in the House of Representatives in March 2018 and are currently waiting to be signed into law.[110] These bills hold websites that “knowingly assist, facilitate, or support sex work” criminally responsible to eliminate sex trafficking.[111][112] The bills had immense bipartisan support with the SESTA-FOSTA passing 97-2 in the Senate after passing through the House. The passage of these bills has already led to the closure of many online communities for sex workers, such as The

Erotic review, that allow sex workers to safely find and screen clients and communicate with other sex workers.[113] Sex workers and free speech advocates alike have greatly pushed back on these bills for endangering sex workers and censoring Internet content.

The increased policing and surveillance of sex workers caused by the growth of the anti-trafficking industrial complex has altered the practices and goals of sex workers rights groups in the United States. Sex workers rights organizations have created programming to combat anti-trafficking practices that are harmful to sex workers and proposed policy and changes in perception of sex workers to protect sex workers against being saved from an occupation they chose. In the presence of increased criminalization and moral criticism, interventions designed by sex workers still center the need to uphold the rights of sex workers. In considering how sex workers can better be cared for within the HIV CoC today, it is crucial to take into account the anti-trafficking industrial complex and how it impacts the daily lives of sex workers. Within COYOTE's research, respondents report local crackdowns on prostitution and feeling more constrained in their work for fear of being arrested and an increased hesitation to disclose their involvement in the sex industry. Any steps taken within healthcare to be more sex worker friendly should be acknowledge the difference between sex trafficking and sex work and put additional effort into making clear to their patients that they will not be reported for being a sex worker.

Conclusion: Implications of Rights-Based Healthcare for Sex Workers

Sex workers in the United States experience the HIV CoC differently than the general public, and this project explores these differences, the context in which they take place, and how distinctive treatment within the HIV CoC impacts sex workers. In the United States, STI prevention campaigns were founded on the goal of eliminating "social evils" in order to maintain the health of the white upper and middle class. Public health institutions looked to directly target these "social evils" and designated sex workers as dangerous vectors of disease.[114] In the past century new STIs, such as HIV, have emerged and STI programming has shifted to covering the entire public and not only sex workers. However, sex workers often remain exceptional within the HIV CoC and this project explored in what ways the notion of sex workers as vectors of disease still exists within STI care and how this impacts sex workers.

Analysis of a nationwide survey finds that the majority of sex workers do not disclose their work to their provider for fear of judgment despite thinking that it could improve their quality of care. For sex workers that do disclose, they report being judged, shamed, infantilized, and asked inappropriate questions about themselves or their work. Additionally, sex workers describe how clinicians often make false assumptions about the risks of their work and neglect take into account other areas of a sex workers life in providing healthcare. Many sex workers face barriers in accessing healthcare outside of HIV care and find because of its focus on sex workers, the HIV CoC can serve as a way to receive other forms of healthcare.

The suggestions put forward in this research focus on treating sex workers as patients deserving of healthcare and not as hazards that need to be managed instead of

cared for. This involves listening to, respecting, not judging, and communicating thoroughly with sex workers in clinical encounters. Respondents urge clinicians and policy makers to not make assumptions about sex workers' health risks and behaviors due to their work. Clinicians were also urged educate themselves on sex work and acknowledge their own stigma against sex workers; the narrative of sex workers as vectors of disease should be named and rewritten by those working with the HIV CoC. Additionally, sex workers suggest that healthcare can provide health education that allows sex workers to stay safe, especially in the face of violence and discrimination in other areas of their lives. Healthcare services that carry out these recommendations should also publicize that they are sex worker friendly and prepared to care for sex workers to allow patients to be comfortable disclosing and building trust with their provider.

Understanding the experiences and suggestions of sex workers is critical in designing health interventions directed at sex workers. The experiences discussed in this study occur within structures built off of stigma against sex workers and a desire to uphold white supremacy and the history of STI care programming must be taken into account in bringing about better health outcomes. Many sex workers are also stigmatized due to their race, gender, sexuality, class, or disability and the ways in which these stigmas function and interact with stigma against sex work must also be examined in considering health interventions. In the past few decades, many researchers and policy-makers in the field of HIV have also sought to address these critical topics in best serving sex workers. New programming and policy has been designed, but only through hearing directly from sex workers is it possible to know how

these changes appear in practice. This project looks to community-based research among sex workers to understand how the current HIV CoC regards and cares for sex workers in order to imagine alternative systems that would better uphold sex workers' right to health.

Incorporating the recommendations of sex workers into existing HIV structures involves actively breaking down the stigma within healthcare that surrounds sex work. Measures to prevent and remedy discrimination against sex workers allow for sex workers receive care that is easier to access and much higher quality care. The HIV CoC holds immense power and visibility within the United States and internal changes made within HIV programming can serve to alleviate discrimination that sex workers face in other areas of their life. Clinicians often function as gatekeepers to knowledge and resources that sex workers may only be able to access through being regarded as patients with rights that are deserving of care. The ability to receive effective and compassionate healthcare allows sex workers to be more stable and able to navigate the intricacies of being criminalized and stigmatized outside of healthcare. Additionally, changes made within healthcare may serve to reframe how other sectors consider sex workers and set an example for how to treat sex workers as laborers with rights instead of a "social evil." Healthcare may be able to serve as a site of breaking down widespread stigma against sex work through emphasizing a right-based approach to working with sex workers instead of existing approaches that frame sex workers as vectors of disease to be managed.

Limitations of this Study and Further Research

This project looked to examine the experiences of a large sample of sex workers within the HIV CoC using mixed-methodology and there were many limitations within the design and goals of this research. Although the sample was large (n=711) and recorded a range of experiences and backgrounds, the nature of the survey as a 145 question online survey did not allow respondents to go in depth about their experiences in the way that interviews or a more directed survey would have. Longer conversations with respondent would have allowed for a more thorough examination of how HIV negative sex workers experience the HIV CoC. Additionally, quantitative data was collected but difficult to analyze and incorporate into many areas of the project because the variables measured were too broad or not scaled to the question. In distributing the survey, it is possible that large communities were not reached or not interested due to lack of compensation or fear of being reported. The mixed-methodology design of this project also made certain areas of inquiry incomplete or difficult to integrate into other areas of the project.

This research also brings up many additional questions to be examined in future projects. Many of the areas of inquiry that would build off of this project surround the plausibility and efficacy of implementing the recommendations of sex workers within the HIV CoC. This research also opens up questions surrounding the criminalization of sex work and the relationship between healthcare and criminal justice fields. Of the many questions prompted by the conclusions of this study, the primary questions are listed below:

1. In what way should clinicians and healthcare policy makers be engaged with sex workers rights? Should HIV care be the entry point to these conversations or does this further the idea of the sex workers as a vector of disease?
2. Are clinical settings able or willing to be trained by sex workers on how to provide sex workers friendly care and publicize that they treat sex workers? What forms of publicity would adequately inform sex workers looking for a provider while not drawing backlash or accusations of supporting a criminalized practice or supporting sex trafficking?
3. What are active ways in which the HIV CoC can work to counter stigma sex workers face in other areas of their lives? Medical professionals hold significant power and influence in American society and if they support a rights-based approach, how could they work to promote sex workers rights in education, housing, migration, and other sectors?
4. How does the HIV CoC as it is today interact with the criminal justice system, particularly laws surrounding prostitution? Have areas of the HIV CoC ever been involved with developing or supporting legalization, Nordic model, or decriminalization proposals in the United States? What would healthcare involvement in influencing decriminalization look like? Is decriminalization even a possibility in the United States? What else would have to happen for decriminalization to be possible?

Inquiry into any of these areas would allow for a much better understanding of how the HIV CoC can provide effective and just care for sex workers. This study

concludes that interventions within the HIV CoC that look to uphold the rights of sex workers and breakdown the stigma surrounding sex work would improve not only the quality of care sex workers receive, but would also address many of the underlying assumption made within HIV care. Within these interventions, sex workers should be treated as patients with agency over their lives and decisions that deserve the same rights as any other patient and not as vectors of disease to be managed for the sake of the rest of the population.

As stated by Weiwei Shein in the sex workers consensus statement before the 2014 AIDS Conference, “We don't need your pity. We need our rights.[115]” Health is a fundamental human right; effective and non-judgmental care within the HIV CoC can play an immense role in assuring that the rights of sex workers are upheld globally. As a sector through which sex work is frequently discussed, HIV care adopting a rights-based approach could serve to reframe the way in which sex workers are viewed in the United States, as rights-holding members of society and not disgraceful vectors of disease. Breaking down stigma and addressing criminalization of sex work are complex issues that require participation from many areas outside of healthcare but changes within the HIV CoC could immediately improve the status of sex workers and serve as an example within the United States.

Terms and Abbreviations

AIDS – Acquired Immune Deficiency Syndrome

APP – Anti-Prostitution Pledge

CoC – Continuum of Care

COYOTE RI – Call Off Your Old Tired Ethics Rhode Island

FOSTA - Allow States and Victims to Fight Online Sex Trafficking Act

HIV – Human Immunodeficiency Virus

IDU – Injection Drug Users

MSM – Men who have sex with men

PEPFAR - The United States President's Emergency Plan for AIDS Relief

SESTA – Stop Enabling Sex Traffickers Act

SW(s) – Sex worker(s)

TW – Transgender women

Appendix 1: Methods

Triangulation

The design of this study is based in public health methodology and incorporates research tools from other disciplines to provide a more comprehensive and dynamic examination of the experiences of commercial sex workers in the United States. The multi-methodological nature of this study allows for an inquiry that not only analyzes the responses to a survey but also explores how questions formulated using a single research method may misrepresent or overlook certain areas of the data. In this way, triangulation provides a thorough formation of research questions and analysis through integrating into a single analysis grounded theory, quantitative analysis, document analysis, and ethnographic participant observation. These four primary research tools used in combination provide a more thorough understanding of the reality of commercial sex workers in addition to examining where certain findings are or are not consistent across fields.

Participants

The data analyzed here were collected over a five-month period from the July 1 to October 31, 2017. COYOTE RI (Call Off Your Old Tired Ethics Rhode Island) collected this data for activist and educational purposes. This study analyzed two of the seven sections of the survey. The survey was administered as an anonymous online survey, and participants were provided with an introduction and consent form to which they checked an “I Agree” button before taking the survey. [Waiting to clarify consent procedure, will update accordingly]. Respondents were not compensated for participating in the survey. The survey was dispersed across the country through sex workers rights organizations and websites used by sex workers to build community and find clients. With administrator permission, survey was posted on review sites such as The Erotic Review, Heaux, TNABoard, and Bigdoggie.net and information about the survey sent directly to Backpage, Erosguide, and Cityvibe listings. The survey was also distributed through the social media accounts (Facebook, Twitter, and Instagram) of organizations led by sex workers such as COYOTE, the Sex workers Outreach Project Behind Bars (SWOP Behind Bars), and the Desiree Alliance.

All participants who met the following criteria were considered eligible for study participation: 1) Currently working in the sex industry or having formerly worked in the sex industry and 2) Currently residing in the United States. These criteria were outlined in the survey introduction and consent form. The sample used in the present study included only respondents who had responded to the following items on the survey: 1) Region of residence, 2) Citizenship status within the US (US citizen, legal resident, undocumented immigrant), 3) Insurance coverage status, and 4) Whether participant ever sought medical care while working in the sex industry. After eliminating missing these items, the total number of respondents equaled 711. On the basis of demographic characteristics, the filtered sample of 711 reflected similar results to the There were no significant differences between the study sample and the overall survey sample and for the remainder of the analysis is of these 711 surveys.

Measures

Quantitative

The 145 question survey designed by COYOTE RI was adapted from a survey administered by GROUP among POPULATION in Alaska in 2015. The survey was composed of seven sections: 1) General Information, 2) Family/Relationships, 3) Sex Work, 4) Economics and Labor, 5) Health, 6) Services, and 7) Criminal Justice System. Only data from the General Information and Health sections were used in this analysis. Quantitative data included multiple-choice questions and questions with a single, numerical response (e.g., age, age of entry, number of year in the sex industry, number of states worked in). General Information included demographic characteristics, immigration status, and involvement in foster care, group homes, or juvenile delinquent centers. Within these demographic categories, the “Other” responses were reviewed, and for two variables, an additional response was added given the high frequency of the same response within the “other” section: for gender identity, “non-binary” was added as a category, and for sexuality, “queer” was added as a category.

Quantitative data exported from the Health section included insurance status, whether or not respondent had sought healthcare services while working in the sex industry, whether or not healthcare services were adequately provided, whether or not

respondent disclosed sex worker status to providers, HIV status, type of HIV care provider, PrEP knowledge, PrEP use, frequency of STI testing, and frequency of condom use while working and not working. Additionally, three open ended questions were categorized as quantitative responses: whether or not respondent thought comfort in disclosing sex worker status would allow for better healthcare; type of healthcare sought while working in the sex industry; type of sex work in which the participant is/was involved.

Qualitative

Qualitative data was collected through short answer open-ended questions and "other" or "additional comments" sections of multiple-choice questions. Qualitative data comprised the majority of data used in this study. and topics covered racial and gender identities, involvement in the sex industry, and history working in the sex industry. Health-related qualitative responses touched on a variety of areas, including: healthcare sought, treatment within healthcare settings, disclosure of sex worker status, reasons to disclose or not disclose sex worker status, STI screening, HIV status, HIV treatment, PrEP knowledge, PrEP use and interest, other prophylactic behaviors, reproductive healthcare, and suggestions for providers.

Document Analysis

Included in this data was the analysis of publications on sex workers and HIV as historical or primary sources. Documents were found through searching terms "sex work" (with all possible endings) + "HIV" and "sex industry" + "HIV" and "commercial sex + "HIV" on PubMed and Google Scholar. These documents were archived and read for common key terms, theories, or conclusions. The frequency of similar findings regarding sex workers and HIV were recorded and key phrases and conclusions recorded.

Ethnographic Participant Observation

Ethnographic participant observation of the sex workers rights movement also played a key role in this research. Before conducting this study, I worked as an intern with

COYOTE RI and was able to note firsthand how sex worker led movements in the US operate and how they interact with and are perceived by the public. I was responsible for connecting with local service providers, sending out the survey, and writing grants and during the five months I worked with COYOTE frequently talked with activists involved in the movement and recorded ongoing events. Through using ethnographic note-taking tools I noted down the activities of the organization itself, its mission, its interactions with other organizations and the general public, and the perception of the organization and its work. Through these ethnographic notes I was able to gather additional qualitative data that provided additional information about the experiences of sex workers, specifically sex workers rights organizing, to provide a more complete picture of the realities of the sex industry in the US today.

Data Analysis

Qualitative

Qualitative data exported from the survey was analyzed using grounded theory, a technique in which researchers identify concepts and build theory from qualitative data.[116] Preliminary questions existed in designing the study but primary research questions were not fully written and finalized until after reading through all of the existing qualitative data. In this way, the questions being asked in this study are borne out of the responses and experiences of sex workers and the four primary questions are: What are the major ways in which Sex workers experience the HIV continuum of care differently than the general public? 2) Does the HIV continuum of care serve as an entry point to other areas of healthcare? 3) What do sex workers want from the HIV continuum of care? and 4) Could HIV continuum of care and sex workers friendly healthcare in general serve as a site to: a) Remedy discrimination in other sectors? b) Influence stigma in and out of medicine, and c) serve to prevent and remedy discrimination? Within each main question there are 1-4 additional follow-up questions to more thoroughly examine the particular area or inquiry. After this preliminary read through and outlining of research questions, the qualitative data was again read and key phrases, words, and theories were identified and coded for. An outline of major themes

and findings was written given these questions, and key phrases and quotes were pulled and organized to support these findings.

Quantitative

Quantitative analysis of data was also carried out, although it played a less fundamental role in examining the key research questions outlined above. In quantitative analysis I calculated the descriptive statistics of the variables outlined in the measures section. Quantitative tables were constructed and these tables were used to reexamine the conclusions reached through qualitative analysis.

Document Analysis and Ethnographic Participant Observation

The findings of the qualitative data were also analyzed and added to through document analysis and analysis of ethnographic notes. The documents were analyzed to determine whether terms or phenomena discussed in biomedical or public health publications aligned with the experiences the survey sample described, and these alignments or differences recorded. Ethnographic notes and document analysis also served to provided additional answer through a different perspective to the primary research questions identified and outlined above.

Appendix 2: Additional Tables

Table 1: Demographics of Respondents

Demographic	Response	n	%
Age		708	99.6
	15-17	4	0.55
	18-24	155	21.89
	25-34	314	44.35
	35-44	137	19.35
	45-54	70	9.98
	55+	28	3.95
Gender		711	100
	Cisgender woman	589	82.84
	Cisgender man	38	5.34
	Transgender woman	17	2.39
	Transgender man	10	1.14
	Non-binary	15	2.11
	Other	41	5.77
Race		711	100
	White	606	85
	Black	51	7.17
	Asian and Pacific Islander	31	4.36
	Native	44	6.19
	Mixed	50	7.03
	Middle Eastern, Arab	1	0.14
	Latinx	63	9.1
Sexual Orientation		710	99.9
	Heterosexual	210	29.58
	Homosexual	30	4.22
	Bisexual	262	36.9
	Pansexual	191	26.98
	Demisexual	20	2.82
	Asexual	19	2.68
	Queer	45	6.34
	Other	19	2.68
Highest Level of Education		710	99.9
	Grammar and/or intermediate school	9	1.25
	High School	167	2.35
	GED	46	6.48
	Vocational Training, technical school	84	11.83
	2 year college	141	19.86
	4 year college	189	26.62
	Masters/Post-Graduate Degree	89	12.53
	Doctoral Degree	17	2.39
	some college	25	3.52
	other	2	0.03
Region of the Country		711	100
	Northeast	69	9.7
	Mid-Atlantic	87	12.24
	Southeast	97	13.64

	Midwest	131	18.42
	Southwest	97	13.64
	West Coast	141	19.83
	Northwest	76	10.69
	Hawaii, Alaska, US Territories	13	1.83
US Citizenship		711	100
	US Citizen	670	94.23
	Legal Permanent Resident, Green Card, Visa	25	3.52
	Undocumented US resident	10	1.41
	Other	6	0.84
Insurance		711	100
	Private Insurance	283	39.8
	State-run	217	30.52
	Uninsured	211	29.68
Type of Sex Work		710	99.9
	Online Escort	384	54.08
	Dominatrix	216	30.42
	Stripper	247	34.83
	Street Worker	63	9.1
	Cam Worker	330	46.53
	Phone Operator	136	19.15
	Porn Performer	183	25.77
	Massage and Bodyrub/Bodywork	266	37.4
	Kink Community	169	24.37
	Sugar Daddy website	269	37.89
	Engaged in survival sex	150	21.13
	Other	96	13.52
Involvement in the Sex Industry		710	99.9
	Currently working in the sex industry	587	82.68
	Formerly involved in the sex industry	123	17.32

Table 2: Type of Healthcare Accessed

Type of Healthcare Sought	n	%
	468	65.8
Primary Care	139	29.7
Mental healthcare	222	13.1
Emergency Room	38	8.1
STI Screening	232	49.6
Care after Assault	7	1.5
Chronic Illness	18	3.8
Accidents or Orthopedics	6	1.3
Gender Affirming Treatment or Surgery	6	1.3
Substance Abuse	2	0.5
Gynecology	24	5.1
Reproductive or Prenatal Care	9	1.9

Table 3: HIV Status and Provider

HIV Status		706	99.3
	HIV Positive	4	0.57
	HIV Negative	686	97.17
	HIV Status Unknown	16	2.27
HIV Care Provider		57	8
	Healthcare Clinic	5	8.77
	Private	23	40.53
	Other	29	50.88

Table 4: PrEP Knowledge and Use

PrEP knowledge		469	66
	Prior knowledge	276	58.85
	No Prior knowledge	193	41.15
PrEP use		414	58.2
	Uses PrEP	33	7.97
	Does not use PrEP	381	92.03

Table 5: Frequency of STI Screening

Frequency of STI screening		704	99
	every 3 months	246	34.94
	every 6 months	178	25.28
	once a year	155	22.02
	less than once a year	79	11.22
	never been tested	31	4.4
	no access to testing	15	2.13

Table 6: Condom Use While Working and While Not Working

Condom Use While Working		614	86.4
	Never	58	9.45
	Rarely	28	4.56
	Sometimes	50	8.14
	Most Often	119	19.38
	Always	358	58.31
	No Access to safe-sex materials	1	0.16
Condom Use While Not Working		680	95.7
	Never	138	20.29
	Rarely	109	16.03
	Sometimes	145	21.31
	Most Often	159	23.38
	Always	128	18.82
	No Access to safe-sex materials	1	0.15

Table 7: Disclosure of Sex worker Status

Disclosure of Sex workers States		494	69.5
	Yes	206	41.7
	No	288	58.3
Does Respondent Think Disclosing Sex worker Status Would Improve Healthcare Received			
	Yes	199	45
	No	110	25
	Other, depends on situation	130	30

Appendix 3: 2014 AIDS Conference Sex Workers Consensus Statements

Melbourne, Australia
Pre-conference meeting among sex workers rights organizations from over thirty countries
Five Primary Topics were identified as key issues sex workers face
Consensus statements were written in collaboration and presented before the 2014 AIDS Conference began
Filmed and distributed by the Scarlet Alliance and the Australian Sex Workers Association

Human Rights and Decriminalization
Rani Ravudi
Survival Advocacy Network, Fiji

1. We believe sex workers should be recognized as the experts in our field and in our lives. We are organized globally and support full decriminalization of sex work, including sex workers living with HIV
2. No criminalization of sex work, our clients, work places, or other laws pertaining to sex work. We unanimously reject models that criminalize sex workers, our clients, and places of employment. This will allow us to advocate for workplace health and safety, access to anonymous, non-judgmental, free and voluntary testing, and quality services, support for safer sex practices and the prevention, treatment and care of HIV
3. The AIDS2014 conference declaration has expressed the shared and profound concern at the continued enforcement of discriminatory, stigmatizing, criminalizing, and harmful laws that lead to policies and practices that increase vulnerability to HIV. Sex workers want to ensure that our laws, policies, and practices parallel this declaration.
4. We want to hold governments and donors accountable to their commitments; step up the pace and turn these policies and commitments into action that result in law reform
5. We demand the inclusion of sex workers as stakeholders in all aspects of policy development
6. All UNAIDS, UNFPA, UNDP, UN family and Global Fund policies must explicitly recognize and support full decriminalization of all aspects of sex work

Stigma and Discrimination
Angkis Lay
Scarlet Timor Collective, Timor Leste

- Recognize the importance of sex worker voices, stop anti-sex workers voices speaking over us
  Combat anti-sex work rhetoric, their arguments are not valid
- Humanize sex work, this costs us the perceived "obligation" of revealing our lives
- Challenge how sex workers are spoken about and prioritize lived experience
- Recognize that stigma exists within the HIV sector
- Sex workers are often trapped between the stigma of being perceived as "vectors of disease" without agency but still remain voiceless even within the HIV sector

Primary Demands
1. You can't stop HIV without sex workers
2. The HIV sector must stop stigmatizing sex workers
3. Sex workers are the experts for and in our community
4. Nothing about us without us. Decriminalization is required to end HIV
5. Sex workers speak from lived experience. Don’t silence us, don't speak on our behalf

Biomedical Research
Maki
SWASH Japan

1. Sex workers are concerned that funding towards biomedical approaches will be taken from sex worker led community interventions
2. Sex workers are concerned about an emphasis on testing without acknowledging: legal barriers, the impact of stigma and discrimination, and barriers to treatment and services limits sex workers ability to access nonjudgmental, quality, voluntary testing, treatment, care, and support services.
3. Current and existing implementations of biomedical approaches are doomed to fail because they don't take into account discriminatory legal frameworks that create barriers to health for sex workers
4. Rapid testing of HIV could lead to enforced or mandatory testing of HIV, STIs, and BBVs and we have no control over what happens to this information
5. Biomedical responses are often imposed without thought of the workplace health and safety of sex workers, which need to be considered before implementation
6. Sex workers are being forced to engage, without consultation, without adequate information so we can choose if and how it can benefit our community. Sex workers face pressure from governments to be tested and pressure from clients who want workers to use PrEP in place of existing safe sex practices.
7. New approaches don't meet the needs of sex workers, we need to maintain and increase funding for sex worker led community programs
8. Legal barriers for sex workers are still so significant that unless we resolve those issues first, through the full decriminalization of sex work, test and treat or treatment as prevention are abstract concepts that have no meaning for sex workers but will divert resources away from approaches that we know work
9. The reality for sex workers is that we have little to gain when an emphasis is put on treatment as prevention
PrEP and early treatment will be used as evidence by police against us just as condoms already are.
Rapid testing = rapid criminalization
10. Sex workers say: for us it's not testing for support, it's screening for control

Funding
Cathy Ketepa, Papua New Guinea

1. Governments must include direct funding for sex workers, including sex workers of all gender, in their strategies.
2. UNAIDS should take leadership on getting sex workers included in national strategies.
3. We want funding for sex workers to consult and provide advocacy within national strategies
4. Sex workers in all countries should be receiving funds under their national strategies
5. We demand those national strategies and their implementation fund sex workers communities directly to do health promotion and human rights advocacy
6. Give the money directly to sex workers. It's what works best and it is cost effective. It's about time!
7. We need funding for sex worker community lead research and work. We have outreach data and want to share this evidence, but we need money for training and to analyze our data.
8. Governments and donors, you lose face if you sign up for global targets, but a the same time gag sex workers from lobbying and advocacy for the changes we need. If you are going to sign up for targets, you need to stop using gag clauses that stop organizations from challenging humans rights abuses against sex workers.
9. Funding needs to have a human rights approach to HIV prevention and support, not a medicalized approach
10. Stop HIV funding to faith based organizations working on sex worker issues. Stop HIV funding to "rescue" and "rehabilitation" organizations
11. We need funding for regional and global sex worker's conferences and sex worker attendance at international conferences and thus funding sex workers to shape the response to HIV.
12. UNAIDS, UNFPA, UN family & Global Fund must integrate human rights into all stages of their grant making processes.

Migration
Weiwei Shein
Myanmar/Burma

1. Detention of sex workers increases HIV risk
2. Sex work is work many sex workers migrate and choose to work just like other sex workers
3. Don’t ignore the evidence. Being a sex worker should not limit our right to migrate. Restricting our movement restricts our access to treatment, care, and support.
4. We oppose mandatory testing of migrant workers upon arrival, and the denial of visas based on serostatus
5. We don't need your pity. We need our rights.

Appendix 4: United Nations International Declaration of Human Rights [Abbreviated]

Article 1	Right to Equality
Article 2	Freedom from Discrimination
Article 3	Right to Life, Liberty, Personal Security
Article 4	Freedom from Slavery
Article 5	Freedom from Torture and Degrading Treatment
Article 6	Right to Recognition as a Person before the Law
Article 7	Right to Equality before the Law
Article 8	Right to Remedy by Competent Tribunal
Article 9	Freedom from Arbitrary Arrest and Exile
Article 10	Right to Fair Public Hearing
Article 11	Right to be Considered Innocent until Proven Guilty
Article 12	Freedom from Interference with Privacy, Family, Home and Correspondence
Article 13	Right to Free Movement in and out of the Country
Article 14	Right to Asylum in other Countries from Persecution
Article 15	Right to a Nationality and the Freedom to Change It
Article 16	Right to Marriage and Family
Article 17	Right to Own Property
Article 18	Freedom of Belief and Religion
Article 19	Freedom of Opinion and Information
Article 20	Right of Peaceful Assembly and Association
Article 21	Right to Participate in Government and in Free Elections
Article 22	Right to Social Security
Article 23	Right to Desirable Work and to Join Trade Unions
Article 24	Right to Rest and Leisure
Article 25	Right to Adequate Living Standard
Article 26	Right to Education
Article 27	Right to Participate in the Cultural Life of Community
Article 28	Right to a Social Order that Articulates this Document
Article 29	Community Duties Essential to Free and Full Development
Article 30	Freedom from State or Personal Interference in the above Rights

Appendix 5: "Nothing About Us Without Us" Report Recommendations[117]

Ensure the leadership of transgender people, especially people of color and leaders with sex trade experience, in all policy discussions pertaining to HIV and sex work

Individuals and organizations must recognize and dismantle cisgender and white privilege within all community and organizational systems in order to create safe and welcoming spaces for all

The federal, state, and local governments should decriminalize sex work and end profiling of trans people

The CDC and other similar federal and state agencies should create policy roundtables or other means through which transgender and sex worker advocacy leaders can shape policies in order to counter the root causes of marginalization—such as stigma, criminalization and police violence— that prevent their communities from accessing HIV treatment and prevention services

The Office of National AIDS Policy, CDC, and other agencies charged with responsibility for implementing the National HIV/AIDS Strategy should form—with strong representation of sex workers and transgender people—an interagency task force on HIV policy for criminalized, stigmatized and marginalized groups to examine issues such as police violence, incarceration, the effects of policing that targets sex work (large events, gentrification "cleanups", etc) and large-scale arrests of sex workers, women of color and transgender people

End the criminalization of condoms for sex workers, trafficking victims and those profiled as such, and ensure adequate access to condoms for all.

End the policing of transgender individuals and identity. End police profiling of transgender people as sex workers through education and sensitivity trainings.

Implement policies that prevent police from searching for medications and from disclosing HIV status

The CDC and related agencies should consult with sex workers and transgender representatives about the limitations of the promotion of PrEP for use in criminalized and stigmatized communities.

Every level of government must ensure that HIV is approached as a health issue, rather than as a criminal issue

All health providers must be required to maintain the privacy of all HIV records. Notably, these records must be inaccessible to law enforcement

States must remove laws and enhancements to standard sentencings that criminalize people living with HIV; Expunge the records of those arrested and charged under such laws that mandate sex offender registration; and Remove people charged under these laws from sex offender registries. In addition, the U.S. Government should adopt a bill such as the REPEAL HIV Discrimination Act, in order to bring the U.S. in line with international legal standards to end

the criminalization of HIV status

Advocacy organizations must prioritize sex worker and trans leadership in campaigns to challenge HIV criminalization and broaden the focus to acknowledge that criminalization of sex work is also HIV criminalization

Ensure access to health care, including hormones and HIV medications, and to essential HIV prevention methods such as condoms in all jails, prisons and detention facilities

Demographic data collected in systems of incarceration must include gender identity and expression for the purpose of housing and reentry of trans women living with HIV

Federal and state governments must enact bail reform to eliminate detaining people for their simple inability to pay bail, and implement other policy changes that would reduce people's actual time incarcerated

Rather than focusing on arrests, human rights based approaches must be emphasized when working with people who have migrated.
More attention should be paid to the conditions of their life both pre and postmigration and how resources can best be allocated to achieve their goals

Remove “participation in prostitution” as grounds for removal from the country, from the category of “crimes of moral turpitude” and as grounds for denying visas/legal status to individuals seeking to visit, reside in, or become citizens of the United States

People incarcerated in detention centers must have consistent access to health care, including hormones and HIV medications, and to essential HIV prevention methods such as condoms

Mandatory HIV testing is a human-rights violation and should not be enforced in any part of policing, court, or prison systems. All testing offered should be confidential, non-mandatory, and made available upon entry and release

Health care settings, particularly in rural areas and small cities, need to be more aware of the privacy concerns of stigmatized populations and ensure that all employees, including, direct service providers as well as desk receptionists and administrative assistants, are held to consistent standards in protecting patient privacy

Policies and programming to support transgender sex workers, especially people living with HIV, must employ whole life approach, such as “housing first” models where housing is provided prior to meeting criteria such as sobriety, not engaging in sex work, etc

Eliminate policies that prevent and hinder individuals with commercial sex- and drug-related convictions from applying for and/or receiving student loans, public housing or housing assistance, public assistance, or other government-funded social services

Transgender specific health care must be accessible without barriers

Syringe exchange must be fully decriminalized and funded; the federal ban on funding for syringe exchange must end; and state level laws and policies must change in order to decriminalize syringe exchange everywhere, especially in the South

Support and fund initiatives for and by trans people and sex workers in rural locations and less serviced areas, emphasizing privacy and related needs

Create support for community-led research on the policy and organizing needs of people affected by HEP C

Expand community-based HEP C testing and referral to treatment initiatives led by and for people who are trans and/or who do sex work

US Government and Foundation funders should adopt a rights-based approach to funding by supporting transgender sex worker-led HIV programming that encourages constituent leadership and meaningful participation in the development and implementation of HIV Funding Policy and promotes sex workers' and transgender people's engagement in social justice and human rights advocacy

US Government and Foundation sectors should provide long-term adequate funding for organizations led by transgender people and sex workers that supports a holistic approach to the health and service needs as identified in this report

Funders of all kinds should reduce the barriers to seeking funding through capacity building amongst community organizations, reduction in bureaucracy and paperwork, and using plain language (rather than highly technical language) in all materials related to the funding process

Include sex workers and transgender people as a priority with indicators in the National HIV/AIDS Strategy, describing the barriers sex workers and people in the sex trade face, and listing these groups in prevention and treatment priorities. Clearly state in all policies the needs and priorities of the transgender community and end the practice of misgendering transgender women as "men who have sex with men" (MSM)

Collect accurate epi-data on the impact of HIV on sex workers and transgender people

Improve communications between government agencies working on HIV and communities affected by HIV (recognizing sex workers, transgender people, and drug users in this dialogue), paying particular attention to meaningfully including voices of people impacted by these policies

Modify or eliminate existing federal policies that conflate sex work and human trafficking and which prevent sex workers and transgender people profiled as such from accessing services such as healthcare, HIV prevention, and support

Repeal and remove "anti-prostitution loyalty oath" requirements entirely for US global AIDS funds and anti-trafficking funds

Provide support for community mobilization of sex workers to respond to the impact of HIV and urge states to work toward the decriminalization of sex work, and end the pervasive criminalization of the lives of sex workers and trans people

Appendix 6: Objectives of Davida [Objetivos de Davida][118]

1. Assure the prominence and visibility of sex workers.
2. Promote public politics in order to exert social control.
3. Obtain legal knowledge of the profession.
4. Promote organization among sex worker, assist the formation of association among sex workers and equip their leaders with the tools necessary for organizing.
5. Reduce the vulnerability of sex workers, especially in the areas of legal rights, health, and safety
6. Denounce and confront stigma, prejudice, and discrimination that impact sex workers.
7. Guarantee and make known the social benefits for sex workers.
8. Fight for better work conditions and quality of life for sex workers

1. Assegurar o protagonismo e a visibilidade social das profissionais do sexo
2. Promover políticas públicas para a categoria e exercer o controle social
3. Obter o reconhecimento legal da profissão
4. Promover a organização de classe, assessorando a formação de associações e capacitando suas lideranças
5. Reduzir as vulnerabilidades da categoria, especialmente nas áreas de direto legal, saúde e segurança
6. Denunciar e enfrentar o estigma, o preconceito e a discriminação que atingem as profissionais do sexo
7. Garantir e divulgar benefícios sociais para a categoria
8. Conquistar melhores condições de trabalho e qualidade da vida para as profissionais do sexo

Appendix 7: Posters from 2015 Campaign by the Brazilian Ministry of Health[119]

“I am happy Being a Prostitute”

“I can’t stay without a condom, love”

“Every Day We Must do AIDS education and Prevention”

“The dream would ultimately be to have society view us as citizens”

"Not Accepting People the Way that the Are is a Form of Violence"

Published directly by DaVida after the Ministry of Health removed the Posters
"I am happy being a prostitute"

Appendix 8: Timeline of Trafficking Legislation in the United States

Major human trafficking and sex trafficking legislation listed below, includes primary but not all trafficking laws in place in the United States today[120]

1910, The Mann Act

- Criminalizes the transportation of minors, and the coercion of adults to travel across state lines or to foreign countries, for the purposes of engaging commercial sex. Both crimes are punishable with up to twenty years in prison, with enhanced punishment options for the transportation of a minor.
- Amended in 1978 and again in 1986

1930, The Tariff Act

- Prohibits importing goods made with forced or indentured labor.

1970, The Racketeer Influenced and Corrupt Organizations Act[121]

- Created to be a tool for the federal government to more effectively prosecute members of organized crime for racketeering offenses. Federal human trafficking offenses are included as racketeering offenses, thus giving law enforcement a powerful tool when prosecuting traffickers.

2000, The Palermo Protocol, "Protocol to Prevent, Suppress and Punish Trafficking in Persons Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime"[122]

- Passed at United Nations Convention Against Transnational Organized Crime in Palermo, Italy
- protocol commits ratifying states to prevent and combat trafficking in persons, protecting and assisting victims of trafficking and promoting cooperation among states in order to meet those objectives.

2000, The Trafficking Victims Protection Act (TVPA)[123]

- Amends the Foreign Assistance Act of 1961 (FAA) to require the Secretary of State (the Secretary) to include as part of required reports on human rights and development assistance and human rights and security assistance:
    - A description of the nature and extent of severe forms of trafficking in persons in each foreign country
    - Transit, or destination for victims of severe forms of trafficking in persons, an assessment of the efforts by such countries' governments to combat such trafficking.
- Requires the President to establish an Interagency Task Force to Monitor and Combat Trafficking, chaired by the Secretary.
    - Authorizes the Secretary to establish within the Department of State an Office to Monitor and Combat Trafficking, which shall assist the Task Force and be administered by a Director.
    - Requires the Director to consult with domestic organizations, international nongovernmental organizations, and multilateral organizations, including the Organization of American States, the Organization for Security and Cooperation in Europe (OSCE), and the United Nations, and with trafficking victims or other affected persons.

2000, Civil Asset Forfeiture Reform Act[124]

- The Department fights human smuggling and trafficking through the issuance of CAFRA, which provides notice to property owners whose properties have been identified as being used to facilitate smuggling or harboring aliens; it is an important tool because many employers turn a blind eye to the facilitation of criminal activity on their properties.

2003, Prosecutorial Remedies and Other Tools to End the Exploitation of Children Today (PROTECT) Act[125]

- The Trafficking Victims Protection Reauthorization Act of 2003 (TVPRA of 2003) established a federal, civil right of action for trafficking victims to sue their traffickers. It also added human trafficking to the list of crimes that can be charged under the Racketeering Influenced Corrupt Organizations (RICO) statute. It also included additional provisions for protection of victims and their families from deportation, and a requirement that the Attorney General report to Congress annually on the activities of the U.S. government in the fight against trafficking.

2003, TVPA Reauthorization[126]

- Established a federal, civil right of action for trafficking victims to sue their traffickers. It also added human trafficking to the list of crimes that can be charged under the Racketeering Influenced Corrupt Organizations (RICO) statute. It also included additional provisions for protection of victims and their families from deportation, and a requirement that the Attorney General report to Congress annually on the activities of the U.S. government in the fight against trafficking.

2004, Intelligence Reform and Terrorism Prevention Act

- Section 7202 of the Intelligence Reform and Terrorism Prevention Act established the Human Smuggling and Trafficking Center to achieve greater integration and overall effectiveness in the U.S. government's enforcement and other response efforts, and to work with foreign governments to address the separate but related issues of alien smuggling, trafficking in persons, and criminal support of clandestine terrorist travel.

2005, TVPA Reauthorization[127]

- Included a pilot program for sheltering minors who are survivors of human trafficking, and grant programs to assist state and local law enforcement combat trafficking. It also expanded measures to combat trafficking internationally, including provisions to fight sex tourism, a $5 million pilot program for treatment of trafficking victims abroad, and a strengthening of the regulation over government contracts to ensure they are not made with individuals or organizations that promote or engage in human trafficking.

2008, TVPA Reauthorization[128]

- Included several new prevention strategies, including requirements that the government provide information about workers' rights to all people applying for work and education-based visas. It also put in place new systems to gather and report human trafficking data. In addition to the prevention strategies, the 2008 reauthorization expanded the protections available with the T visa, and required that all unaccompanied alien children be screened as potential victims of human trafficking. This reauthorization also enhanced criminal sanctions against traffickers, and expanded definitions of various types of trafficking to make prosecution easier.

2009, The Customs and Facilitations and Trade Enforcement Act[129]

- Amended the prohibition on importing goods made with slave or indentured labor to include goods made through the use of coercion or goods made by victims of human trafficking.

2013, National Defense Authorization Act[130]

- Seek to limit human trafficking associated with government contractors. These sections give governmental agencies the ability to terminate, without penalty, any contract or grant with any organization or individual that engages in human trafficking. It also requires that all grants and contracts worth more than $500,000, have a written certification that no party in the transaction will engage in or support human trafficking practices. It also establishes methods of reporting and investigating possible instances of human trafficking associated with government contracts and grants.

2013, TVPA Reauthorization[131]

- Establishes and strengthens programs to ensure that U.S. citizens do not purchase products made by victims of human trafficking, and to prevent child marriage. It also puts into place emergency response provisions within the State Department to respond quickly to disaster areas and crises where people are particularly susceptible to being trafficked. The reauthorization also strengthens collaboration with state and local law enforcement to ease charging and prosecuting traffickers.

2014, The Preventing Sex Trafficking and Strengthening Families Act [132]

- Seeks to reduce the incidence of sex trafficking among youth involved in the foster care system. The portion of this law specific to sex trafficking requires child welfare systems to improve their response to sex trafficking by screening and identifying youth who are sex trafficking victims or those who are at risk for sex trafficking, provide appropriate services to youth who experience sex trafficking, report missing children to the National Center for Missing and Exploited Children, and develop protocols for locating missing or runaway children and determine what circumstances they faced while away from care.
- State child welfare agencies are required to report instances of sex trafficking to law enforcement and provide information regarding sex trafficking victims or at-risk youth to the U.S. Department of Health and Human Services, who will in turn report these numbers to Congress.

2015, The Justice for Victims of Trafficking Act[133]

- Improves the U.S. response to human trafficking. It contains a number of important amendments that strengthen services for victims. Among these amendments are changes in the criminal liability of buyers of commercial sex from victims of trafficking, the creation of a survivor-led U.S. Advisory Council on Human Trafficking, and new directives for the implementation of a national strategy for combating human trafficking.
- Requires the creation of a domestic trafficking victim's fund to support victim assistance programs, block grants for child trafficking deterrence programs, and additional training requirements for first responders, among others. Notably, the JVTA amended the Runaway and Homeless Youth Act (RHYA) by declaring youth who are victims of severe forms of trafficking in persons are eligible for services under the RHYA. It also amended the Child Abuse Prevention and Treatment Act (CAPTA) by adding human trafficking and child pornography as forms of child abuse.

Federal Trafficking Laws, The Numbers

Number of federal bills addressing human trafficking and sex trafficking introduced and signed into law since the signing of the Palermo Protocol and Trafficking Victims Protection Act (2000 – 2018)

115th Congress (2017-2018)
- 10 bills signed into law
- 68 laws introduced

114th Congress (2015 - 2016)
- 13 bills signed into law
- 109 bills introduced

113th Congress (2013 - 2014)
- 7 bills signed into law
- 91 bills introduced

112th Congress (2011 - 2012)
- 5 bills signed into law
- 49 bills introduced

111th Congress (2009 - 2010)
- 5 Bills signed into law
- 37 Bills introduced

110th Congress (2007 - 2008)
- 6 Bills signed into law
- 22 Bills introduced

109th Congress (2005 - 2006)
- 11 Bills signed into law
- 35 Bills introduced

108th Congress (2003 - 2004)
- 12 Bills signed into law
- 49 Bills introduced

107th Congress (2001 - 2002)
- 6 Bills signed into law
- 29 Bills introduced

106th Congress (1999 - 2000)
- 10 Bills signed into law
- 59 Bills introduced

Trafficking Legislation at a State Level

Year first state trafficking legislation signed into law

2003
- Washington
- Texas

2004
- Florida
- Missouri

2005
- Arizona
- Arkansas
- California
- Illinois
- Kansas
- Louisiana
- Nevada
- New Jersey

2006
- Alaska
- Colorado
- Connecticut
- Georgia
- Idaho
- Indiana
- Iowa
- Michigan
- Minnesota
- Mississippi
- Nebraska
- North Carolina
- Pennsylvania
- South Carolina

2007
- Delaware
- Kentucky
- Maryland
- Montana
- New York
- Rhode Island
- Oregon

2008
- Hawaii
- Maine
- New Mexico
- Oklahoma
- Tennessee
- Utah
- Wisconsin

2009
- New Hampshire
- North Dakota
- Vermont
- Virginia

2010
- Alabama
- District of Columbia
- Ohio

2011
- Massachusetts
- South Dakota

2012
- West Virginia

2013
- Wyoming

During the 2013 - 2014 legislative year, 37 states passed new trafficking legislation [trafficking laws were already in place in every state]

All states have laws in place to specifically address trafficking and all but 12 states (Alaska, Arizona, Colorado, Idaho, Iowa, Maine, Michigan, North Dakota, Rhode Island, South Dakota, Virginia, West Virginia) have laws to support victims of trafficking

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